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GOVERNMENT AND MEDICINE ABROAD

REGULAR FEATURES

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GOVERNMENT AND MEDICINE IN BRITAIN

Our July issue is the second part of our three issue study of the problem of government responsibility for medical care. In this issue seven specialists will appraise the British National Health Service.

Medical Care before World War II

by SAMUEL J. HURWITZ, Associate Professor of History, Brooklyn College;

The Genesis of the N. H. S.

by HARRY ECKSTEIN, Professor of Politics, Princeton University, and author of "The English Health Service";

The N.H.S. in Its First Decade

by ALMONT LINDSEY, Professor of History, Mary Washington College, and author of "Socialized Medicine in England and Wales";

The Cost of the N.H.S.

by GORDON FORSYTH, Lecturer in Social Administration, Victoria University of Manchester (England), and author of "The Demand for Medical Care";

The British Doctor Today

by F. J. SPENCER, Chairman of the Department of Preventive Medicine, Medical College of Virginia;

National Health Service: No

by JOHN RECKLESS, Duke University Medical Center, and formerly a practicing physician under the N.H.S.;

National Health Service: Yes

by SIR GUY DAIN, member of the Central Advisory Council for the British Ministry of Health, 1945–1950.

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HIGH SCHOOL DEBATERS: NOTE THESE 3 issues on the 1963–1964 N.U.E.A. DEBATE TOPIC.

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CURRENT History

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In this issue seven specialists examine the roles and responsibilities of government in providing for the health of their citizens in various nations abroad, the first issue in a 3-issue study of this problem. As our introductory article points out, some public health duties are generally accepted by all governments. "The question confronting the United States and some other countries which do not yet have socialized medicine is to what extent the government should assume responsibility for all the medical problems that confront the individual."

The Outlook for National Medicine

By W. Horsley Gantt
Director of the Pavlovian Laboratory, Johns Hopkins University

We live in an era that is changing so fast that we ourselves can hardly become acclimated to the culture of today before it is swept away by the inventions of tomorrow. To cite but one example, that of transportation: within the memory of those now living, to traverse a distance of 20 miles with horse and buggy took as long as to orbit the earth now ten times.

In some ways medicine has kept pace with this scientific progress. In our twentieth-century life we have witnessed the eradication or control of some of the most serious infections—tuberculosis, typhus, malaria, cholera, smallpox, yellow fever; the elimination, through the discovery of the causes, of pellegra, beri-beri, scurvy; the reduction of infant mortality; the prevention of poliomyelitis. These achievements have been effected through scientific research on the one hand, and on the other hand, the organization of national or even international public health systems.

In many branches of medicine, however, there has been little or no advance. Indeed some diseases have increased. Among them are those requiring surgery (accidents and tumors); those resulting from our changed ways of living such as cardiovascular disorders, neuroses and psychoses; and a variety of behavioral problems ranging from juvenile delinquency to catastrophic wars.

For the delegation to a central authority of the responsibility for sanitation, water supply, food and drug control, quarantine against infections, and certain other public health measures, both the public and the medical profession are in accord. Scientific research, also, which was previously supported either through individual effort or through philanthropy is now largely underwritten by governments. The question confronting the United States and some other countries which do not yet have socialized medicine is to what extent the government should assume responsibility for all the medical problems that confront the individual.

Aside from the fact that a residuum of pathologic conditions does not yet yield to prophylaxis, there are certain other pertinent factors. Because of the uncertainty of both the duration and the nature of disease and the greatly increased cost of modern hospital care, it is not feasible for the average individual to provide for the adequate treatment of unusual and chronic illnesses.

The cause of the increased expense of modern hospital care is not only due to the tremendously greater cost of individual attention through nursing and so forth, but also paradoxically to greater scientific knowledge. Medical advances require a great number of instruments, skilled technicians and doctors. Formerly a patient was treated at home by a member of the family and without benefit of all the instrumentation which modern medicine now uses for diagnosis or for treatment. The expense of these procedures has far exceeded the increased earnings of the individual.

The increase in the average length of life means that prolonged aging and chronic disease are more frequent. Since illness is not a profitable occupation, the cost cannot be easily passed on to the consumer, the consumer being the one who is at least temporarily incapacitated. For the aged the cost must often be borne by family or society.

Thus we see that the question of socialized medicine does not primarily concern mortality and the gross health of the nation, since these functions have been taken over by governments in all civilized countries, but the personal problems of the individual. Since the trend, however, of our new national cultures is to make the government responsible for an ever increasing number of the citizen's activities, nationalized medicine looms on the horizon. We are passing from the stage of the wild and self-sufficient beast to that of the well-regulated domestic animal.

THE HEALTH SERVICE IN BRITAIN

Long before the National Health Service was inaugurated, the "welfare state" was conceived. Lord Beveridge had formulated the idea of the "welfare society," a group with responsibility for one's neighbors rather than recipients of a national bounty. *The Manchester Guardian* in March, 1963, stated that Beveridge was greatly disillusioned at the growing lack of individual responsibility in Britain.

In 1907 personal medical services were provided partly at government expense. This was followed in 1912 by the National Health Insurance Plan, introduced by Lloyd George, supported by Bevan. It was intended to provide for the poorer sections of the population.

After the Second World War one-half of the British population was included in the National Health Insurance. However, owing to farsighted political action, the strength of the trade union movement, the dissatisfaction of the neglected middle class, and the trend of the times, the voluntary insurance societies were replaced by the N.H.S. However, this service did not take concrete form until it became law on July 5, 1948. The N.H.S. became law through the activity of the deputy secretary of the British Medical Association, Dr. Charles Hill, a conservative, who, according to Richard Mackarness, pushed it through by splitting the vote of the medical specialist and the general practitioner. "He knew it was coming and he wanted to be on the wagon."

The N.H.S. in Britain is one of the newest of the national systems and one of the most comprehensive. Theoretically it can provide for most of the medical needs of the individual; it is the largest single expenditure in the budget, employing 300,000 people and 95 per cent of the medical profession.

The N.H.S. in Great Britain has perhaps excited more controversy than have the medical systems of Scandinavia or of Russia. Of its four divisions—public health, research, the medical specialties (including hospital services), and general practice, the latter has met with most criticism from the medical profession. Articles have appeared in British medical journals by committees as well as by individual practitioners bemoaning the defects of the system. Apparently there has not been excessive misuse of the physician's

time by night calls, perhaps because of the basic training of the average Britisher not to impose upon his neighbor. Harry Eckstein states that the American doctor drawing over a $10,000 salary made 5.5 calls annually, the Britisher under the former National Health Insurance, 5, and under the present N.H.S., 6. The national health statistics have improved and infantile mortality has declined.

Any failure, according to R. K. Allday, has not been due to the abandonment of the Hippocratic ideal of the doctor, nor to wanton abuse by the public, but to the ineffectiveness of the system.[1]

SCANDINAVIA

Medicine in the Scandinavian countries (Norway, Sweden, Finland, Denmark, Iceland) has certain general characteristics differing in each country and colored by both the national traits of the peoples and their geographical status. With the exception of Finland, these countries have a remarkably homogeneous population of Nordic stock. Finland differs in its ethnic origins, but its traditions are mostly Swedish. Its population is about 10 per cent Swedish, the rest Finnish and other races. Finland was ruled by Sweden until 100 years ago when it was transferred to the domination of Russia, but in spite of this it has always maintained to an extraordinary degree its independence and self-sufficiency.[2]

"The basic features of public health administration are practically identical in all the Northern countries."[3] Private practice ranges from a low of 38 per cent of the doctors in Sweden to 58 per cent in Denmark, those in hospital practice from a low of 22 per cent in Iceland to 46 per cent in Sweden. In Denmark, the voluntary health insurance societies, covering 80 per cent of the population, are obligated to give free medical care to their members. In countries other than Denmark, owing to the great distances separating the people, the public health officers also have the responsibility for general medical care in the rural districts, while in the towns medical care is left to the private practitioners. Hospital care is in the hands of special hospital doctors, separate from the rest of the medical profession. The actual number of doctors varies from a low of 1 to about 2,000 in Finland, and 1 to 1,400 in Sweden to 1 to 900 in Iceland.

Under "Social Insurance" are included health and unemployment insurance, old age and disability pensions. In contrast to the early German idea of social insurance for workers, the Scandinavian countries believe that the whole population should be covered, or at least all but the most opulent. The insurance is paid for chiefly by the governments, two-thirds of this cost coming from the public revenues in Sweden and Denmark, and 30 per cent in Finland and Norway, the rest from the employers and the people. Old age pensions are financed in Denmark entirely by the government, in Norway one-half and in Sweden one-fourth by the government.

Health insurance, beginning about 1850 in Denmark and Sweden, derived from the former guilds and later from the temperance societies. State support began in Sweden and Denmark in 1891. Voluntary health insurance in Norway became compulsory in 1909 and is gradually extending its limits. In Iceland in 1946 the whole population was included in social security. In Finland health insurance chiefly applies to industrial workers and is not supported by government finances. The health insurance except for Finland is generally open to the whole population; it covers 96 per cent of the population in Denmark, 60 per cent in Sweden, and about 85 per cent in Norway.

RUSSIAN MEDICINE

The present health system in Russia is based on pre-revolutionary Russian medicine

[1] For further information about the British Health Service see the forthcoming July, 1963, issue of *Current History*.

[2] Finland has had an exceptionally difficult position of preserving its independence while being under the domination of a country (Russia) whose traditions are foreign to it. Finnish efficiency and responsibility were exemplified by its uniqueness in repaying to the United States the debt incurred in World War I.

[3] See also pp. 333–338 of this issue.

and on the cataclysmic changes following the Bolshevik Revolution. The czarist system produced a few first class scientists, doctors and institutes, but practically no public health system. There was only one doctor for several thousand people; there were recurring mass epidemics of smallpox, typhus, cholera, and a death rate of 28.5 per 1,000 in 1911–1913.

Today Russia has progressed to the point where it has eliminated most of its decimating epidemics, reduced its death rate to almost the level of the United States (about 8 per 1,000), and inaugurated public health measures that in some ways are more advanced than those of the Western nations. Indicative of the progress of Russian medicine is the fact that on my last visit to the U.S.S.R. in 1958, I found that the chief causes of death were no longer epidemics, but diseases we have in the West—cardiovascular disorders and cancer.

In the transition from a feudal, illiterate, predominantly peasant population to an almost modern, mechanized industrial society, Russia has suffered periods of great famines (the one of 1933 equal in magnitude to the pre-revolutionary famines), hard, militaristic living conditions and tremendous personal privations. Today, the conditions are becoming more and more similar to those in the United States. As we become more strongly centralized, Russia is tending toward decentralization and more local freedoms.

In the medical field, we can see perhaps the most successful application of humanitarian principles that Marxism has provided in a country that calls itself Marxist. Besides the great increase of medical facilities through the education of doctors (there is now one per 700 people), there have been several special advantages of the Russian health system: the education and protection of children and maternity cases, universal social insurance, the provision of paid vacations and of "rest homes." The insurance covers all forms of disability and sickness with old age pensions.

In spite of the provision of public medical services for every citizen, private practice still exists. Office hours are short (6 hours) outside of which the doctor may accept private patients. There are many inconveniences and defects for the individual: it is difficult to receive medicines or medical attention at home; there is a long waiting line for hospital beds.

As far as the doctor is concerned, the American system appears more socialized than the Russian. In the United States, a general practitioner or an established clinician may be paid more than the professor of medicine. The young doctor two years out of medical school can receive 50 per cent of the salary he would get at the end of his career. In Russia, the clinician receives not much more than a school teacher or a clerk and only about 10 per cent of what the professor of medicine (and also other professors) or the scientist receives. In privileges, honor, prestige and money Russia accords first place to those considered most important: the eminent artist, scientist, litterateur. These rank with the high politicians.

To those who think that any kind of socialization means equal privileges, I quote what a Russian Communist said to me in Moscow in 1958:

> Although we have free rest homes and sanitoria, in the Crimea where former aristocrats had their villas, we see the same problems now that you have: there are only places for a small percentage of the population, and the question is who will occupy these choice resort spots, who will get the front rooms.

THE U.S. AND SOCIALIZED MEDICINE

In a previous generation, people were organized into small communities which oriented about the church, the school, the minister, the family doctor. The public had an image of the family doctor as a "dedicated" man, devoted to his task of healing the sick, with only a secondary thought for his own welfare. He was accustomed to treat the needy without recompense and to risk his life against contagious disease.[4]

[4] My grandfather, who graduated from the University of Pennsylvania in 1845 and died in 1881, often spent 16 hours a day in the saddle on his rounds and sometimes received as his fee at the end of three months a string of red peppers.

Changes in living habits, the growth of hospitals and of specialization in medicine, the assumption of public health responsibilities by the state have reduced the function of the general practitioner, and have transformed his image in the public mind. Now people depend less upon the private doctor than upon comprehensive examinations in a clinic or referrals to several doctors.

The physician is furthermore a bad public relations man. By training he is accustomed not only to self-sacrifice but to arbitrary rule and to acting with authority towards a patient. So strong is this tradition that many a doctor hestitates to treat a patient if his opinion and authority are questioned.

For these reasons the medical profession has been less capable of presenting its case before the public. The American Medical Association often comes off second best in opposing socialized medicine against the onslaughts of organized labor (COPE). When the A.M.A. speaks for the rights of the physician, he appears in the public eye sordid, callous, and self-seeking, destroying the image of the "good physician." (This, in spite of the fact that most American doctors —with the exception of some branches— seldom refuse to treat a needy patient, though often free treatment is given through a clinic instead of in the office).

Besides an enormous amount of free or charity treatment in the United States, there is a large sector of real socialized medicine, where medical services are provided within an organization and without freedom to choose the doctor, e.g., the Veterans Administration, the armed forces, and some institutes.

There are over 20 million veterans in the United States many of whom can receive free treatment in the nearly 200 hospitals administered by the V.A. Treatment in the V.A. hospitals may not only be provided to those with service-connected ailments but also to those veterans with other diseases who produce evidence that they are unable to pay.

Members of the armed forces as well as many government officials and their families receive free medical attention at Walter Reed Hospital in Washington or at other medical centers. As Dr. Louis Goodman points out, President Eisenhower has never had to pay a medical bill since he entered West Point as a cadet. Many universities and other institutions now offer some kind of free medical service to their employees. Blue Cross and private insurance companies are said to provide sickness insurance to over one-half of the population.

The A.M.A. sponsored the Kerr-Mills statute of 1960 which furnishes federal aid for medical treatment to those states (now about two-thirds of the states) which are willing to contribute an equal share of the costs from the state budget. The Kerr-Mills Act applies only to those needy who are over 65. This law allows the state to decide what assistance to supply, but Congress made it possible to include everything from spectacles and dental work to hospital costs.

The King-Anderson bill was drawn up by Wilbur Cohen, Assistant Secretary of Health, Education and Welfare, at the behest of President Kennedy for new medical care legislation. The A.M.A. endorsed the Hill-Burton bill for hospital construction and the Kerr-Mills bill, but vehemently opposed the Anderson-King proposal for several reasons: it is not adequate for those in need; it provides for those who can afford to pay; it is political, being tied to Social Security and to central control.

Advocates of more government control of

(*Continued on page 368*)

Dr. W. Horsley Gantt is emeritus professor of psychiatry at the Johns Hopkins University. He is the principal scientist at the Veterans Administration Hospital in Perry Point, Maryland. From 1925–1929 Dr. Gantt studied the physiology of the brain in the laboratories of Professor Pavlov in Petrograd, Russia. He received the American Heart Association award in 1955 for research on causes of high blood pressure and the Lasker Award in 1946 for research in nervous diseases. Author of several books, his most recent publication is *Physiological Psychiatry* (1958).

"The joint Dominion-Provincial Hospital Insurance and Diagnostic Services Programme," according to this writer, "is well-accepted by the hospital associations, the medical profession, and the public." Under the program ". . . services in active treatment, chronic, and convalescent hospitals and in other approved facilities are universally available to all residents."

Canada's Health Programs

By JOHN E. F. HASTINGS

Associate Professor of Public Health and Preventive Medicine, School of Hygiene, University of Toronto

ALTHOUGH THERE was some earlier interest in health insurance in Canada, it was not until 1942 that formal steps were take at the national level. Reports on health insurance and over-all social security were prepared in 1943.[1,2] A draft health insurance bill was drawn up by the Special Committee on Social Security of the House of Commons in 1944.[3] Under the British North America Act (Canada's constitution), the provinces have major responsibilities for health services. Accordingly, the Dominion Government prepared proposals for making grants to assist the provinces in developing health insurance programmes. Because of a deadlock over the allocation of tax powers, the proposals were not discussed formally at the Dominion-Provincial Conference on Reconstruction in August, 1945.[4]

Subsequently, instead of an expected post-war depression, a period of prosperity occurred. Rapid growth of hospitalization insurance plans and more gradual growth of insurance plans for physicians' services took place under hospital association, professional association, co-operative organization, and private insurance company auspices. Interest at the national level in a government programme waned.

However, several provinces established programmes of their own. The Saskatchewan Hospital Services Plan began in 1947[5] and, in one district of the province, the Swift Current Medical Care Programme was started in 1946. The British Columbia Hospital Insurance Plan was established in 1949.[6] In 1950, Alberta began to support the development of separate provincial-municipal hospital insurance plans.[7] Newfoundland entered Confederation in 1949 but had operated the Cottage Hospital and Medical Care Plan for the outports since 1935. In 1957, the Newfoundland Children's Hospital Plan was started. A Catastrophic Hospital Care Plan was set up in Manitoba in 1957.[8]

[1] Canada, House of Commons, Special Committee on Social Security, *Health Insurance: Report of the Advisory Committee on Health Insurance* (Ottawa: King's Printer, 1943). ("Heagerty Report").

[2] Canada, The Labour Gazette, April, 1943, "Report on Social Security for Canada, 1943," ("Marsh Report").

[3] Canada, House of Commons, *Minutes of Proceedings, Special Committee on Social Security*, No. 13, July 22, 1944 (Ottawa: King's Printer, 1944).

[4] Canada, *Proposals of the Government of Canada, Dominion-Provincial Conference on Reconstruction*, August, 1945.

[5] Public ward care as medically required.

[6] Chronic stage of chronic illness not covered.

[7] A number of municipal hospital districts had their own plans before 1950. Precise benefits varied from plan to plan.

[8] The province paid all standard ward costs after the first 180 days. The plan was discontinued on July 1, 1958.

The Dominion Government in 1948 began the National Health Grants Programme of grants-in-aid to the provinces for provincial health surveys, for the improvement and development of public health services, for hospital construction, for the education of health service personnel, and for other services.[9] In January, 1956, the Dominion Government presented proposals for financial and technical assistance for standard ward hospital care and for laboratory and radiological diagnostic services at a meeting with the provinces. After further discussions, the Hospital Insurance and Diagnostic Services Act was passed in April, 1957.[10] The programme began on July 1, 1958.

In December, 1960, the Prime Minister announced that a Royal Commission on Health Services would be appointed.[11] Several hundred briefs on all aspects of health care, including manpower and education, as well as administration, programme, and financing, have been received. All major briefs recognized universally available, comprehensive benefits as an ultimate objective. However, there were definite differences of view over the methods for achieving this end. In general, the official medical organizations, business associations, and the private insurance industry recommended some type of government subsidization of non-government insurance carriers to permit enrolment of low income, public assistance, and "high risk" groups, whereas trade union and certain other organizations generally recommended full government programmes. Many briefs concerned special health problems and services, such as rehabilitation and mental health. A number of expert studies were also commissioned. A report is to be presented to the Government in the summer of 1963; the special studies are to be published.

The Medical Care Plan in Saskatchewan is discussed later. Alberta has passed legislation to permit provincial subsidization of private carriers from July, 1963. Ontario is expected to introduce general enabling proposals, to be referred to special committees for further detailed study. Other provinces are also studying the question.

PUBLIC HEALTH SERVICES

The Dominion Government offers financial assistance and a wide range of consultative and laboratory services to the provinces in the public health field. It provides directly public health services of an international and national nature only. Each province has its own health department and public health legislation. Except for large cities with municipal health departments, local public health services in most provinces are provided through health units or districts, which are provincially administered and staffed and largely provincially financed. However, in Ontario, municipal responsibility for public health services has been retained, though financial assistance and consultative services by the province have increased. Over 80 per cent of the population live in areas with full-time, public health services.

Programme details vary across the country, but in general include communicable disease control, tuberculosis control, venereal disease control, environmental hygiene, maternal and child health, school health, and public health nursing services. Commonly services such as mental health, dental health, chronic disease screening, nutrition, and, in rural areas, limited visiting and bedside nursing are also provided. Voluntary visiting nursing associations are active in most large communities.[12] Organized homemaking services, where available, are provided by voluntary[13] and proprietary agencies.

Concerning the Dominion-Provincial Hospital Insurance and Diagnostic Services Pro-

[9] In 1961–62, expenditure of about $49 million on grants for hospital construction, professional training, general public health, public health research, mental health, tuberculosis control, cancer control, child and maternal health, and medical rehabilitation.

[10] Canada, *Hospital and Diagnostic Services Act, April 12, 1957*. (Elizabeth II).

[11] Composed of a judge, as chairman, two doctors, a dentist, a nurse, an economist, and a businessman with welfare interests. The latter member resigned in 1962 when appointed to the federal cabinet and to the Senate.

[12] Most municipalities and several provinces pay grants to these agencies for services to indigent residents.

[13] In a few municipalities, local and provincial grants are made for services to indigent residents.

gramme, all ten provinces and two territories have established plans in agreement with the Dominion Government. Services in active treatment, chronic, and convalescent hospitals and in other approved facilities are universally available to all residents.[14,15] The length of stay in hospital is determined by medical need. People are free to purchase coverage for additional benefits from Blue Cross and private insurance company plans. In each province consultant services are available to the individual hospitals to encourage quality of service. Common accounting procedures and budgetary control are used.

Mandatory in-patient services are: (1) standard ward accommodation and meals, (2) necessary nursing services, (3) laboratory, radiological, and other diagnostic procedures plus interpretations, (4) in-hospital drugs, biologicals, and related preparations, (5) use of operating room, case room, anaesthetic facilities, and equipment, (6) routine supplies, (7) use of radiotherapy facilities where available, (8) use of physiotherapy facilities where available, (9) services of people paid by the hospital,[16] (10) any other services specified in a provincial agreement.[17]

Permissive out-patient services, for which the costs are shared, vary from province to province. A few limit out-patient coverage to emergency care;[18] most also provide services which would otherwise lead to admission; some cover a wide range of benefits, for example, minor medical and surgical procedures, radiotherapy for malignancy, physiotherapy, laboratory, radiological and other diagnostic procedures, and electro-shock treatments. In general, the trend has been towards a widening of out-patient benefits.

Exclusions by the Dominion from shareable costs include: (1) Services of a private general physician or specialist; (2) Care in tuberculosis sanatoria and mental hospitals (Care in these institutions has long been accepted as a provincial responsibility. However, costs of care in psychiatric wards of general hospitals and in wards of sanatoria which have been converted to general, chronic, or convalescent hospital use,[19] are shared by the Dominion); (3) Nursing homes and custodial institutions (Separate legislation in most provinces provides assistance for nursing homes and for homes for the aged and other predominantly custodial institutions); (4) Capital cost, depreciation, and debt (Dominion assistance is given through the Hospital Construction Grants.[20] It was felt that local identification with hospitals and local initiative for raising part of capital funds should continue. Variation in capital debt for hospitals in 1958 made Dominion contribution difficult. The provinces and their municipalities have worked out solutions for capital debt and depreciation costs).

FINANCING

The Dominion Government payments come from general taxes. Each province receives the aggregate in the year of 25 per cent of the per capita cost of in-patient services in Canada as a whole and 25 per cent of the per capita cost of in-patient services in the particular province[21] multiplied by the

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[14] Except members of the Armed Forces and the Royal Canadian Mounted Police, who are covered under other Dominion programmes.

[15] Ontario and Prince Edward Island do not require everyone who is eligible to enrol.

[16] Full-time paid staff, such as nurses, interns, hospital administrators, physiotherapists, occupational therapists, medical social workers, and orderlies.

[17] For example, this could include a hospital-based cancer diagnostic and radiotherapy programme available to all residents in a province or hospital-based rehabilitation programme.

[18] Varies from 24 to 48 hours following an accident and may include subsequent check x-rays on a fracture and change or removal of a cast. Alberta provides no out-patient benefits except to social assistance pensioners and their dependents.

[19] In some provinces, for example Ontario, for administrative purposes the provincial programmes for financing care in tuberculosis sanatoria and in mental hospitals have been transferred to the hospital plans. However, the full cost of such care continues to be a provincial responsibility.

[20] One of the grants under the National Health Grants programme. Federal expenditure in 1961–1962 was about $19 million. The provinces must at least match the grants for hospital construction or renovation. Most municipalities also provide hospital capital grants. Other health grants for rehabilitation, laboratory, and x-ray facilities and equipment may be used for hospitals.

[21] If a province charges a co-insurance payment directly to the patient at the time benefits are received, 25 per cent of the per capita amount of such charges is deducted from this calculation.

average covered population in the particular province for the year. This represents on the average 50 per cent of shareable costs for the country as a whole but the actual proportion of costs covered for any one province varies. Under the formula, a higher proportion is paid to poorer provinces, which generally have lower costs, than to wealthier provinces, which generally have higher costs.[22] The costs of out-patient benefits accepted on a shareable basis by the Dominion are paid at the same percentage rate as for in-patient benefits.

Provincial shares are met in various ways. Some use general or special tax revenues entirely.[23] Four also have premium systems,[24] two levy co-insurance charges against beneficiaries[25] to help meet part of the costs. All residents are covered compulsorily except in Ontario and Prince Edward Island, where enrolment is compulsory for most but not all residents.[26] Special arrangements are made to cover people on public assistance in provinces with premium payments.

Over 90 per cent of the operating expenditures of hospitals in Canada are covered from public sources.[27] Other than the hospital plans, these include federal payments for in-patient care to veterans, servicemen, and the Royal Canadian Mounted Police, provincial payments for tuberculosis and mental hospital care, and Workmen's Compensation Board payments for in-patient care to injured workmen.

Five provinces administer their plans through the provincial health departments. Two have a section directly under the minister of health but separate from the public health administration. Three have hospital commissions which report to the legislatures through the ministers of health.

The Joint Dominion-Provincial Hospital Insurance and Diagnostic Services Programme is well-accepted by the hospital associations, the medical profession, and the public. Capital costs continue to present difficulties in many communities, because of the difference between government grants and actual costs. General hospital bed shortages, especially in growing urban communities, are being met as quickly as possible.

Provincial medical associations have been more or less reluctant to see out-patient benefits extended. An initial difficulty in most provinces arose over payment for the in-hospital services of pathologists and radiologists. After negotiations the question has been settled either by agreed salary or, more commonly, fee-for-service arrangements.

Two difficulties, as in most economically developed countries, are rising bed utilization rates and rising costs. These trends were present previously since many people had some coverage for in-hospital costs under Blue Cross and other private plans. Various provinces have made studies of methods for keeping costs at an acceptable level and for financing alternative forms of care, for example, organized home care and nursing homes. There has also been emphasis on building chronic care and convalescent facilities.

DOMINION GOVERNMENT PROGRAMMES

The Dominion has comprehensive, tax sup-

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[22] For example, the 1959 Dominion contribution to Newfoundland covered approximately 62 per cent of shareable costs as compared to 43 per cent for Saskatchewan.

[23] Newfoundland, Nova Scotia, New Brunswick, and Quebec.

[24] Prince Edward Island, Ontario, Manitoba, and Saskatchewan—vary in total from $24.00 to $25.20 per year for a single person and from $48.00 to $50.40 per year for a family.

[25] Alberta—Between $1.50 and $2.50 per day ($1.00 per day for newborns), based on the size of hospital. The province pays the co-insurance for maternity, arthritis, cancer, poliomyelitis, and public assistance recipients. Alberta also has municipal participation through taxes based on property assessments. British Columbia—$1.00 per day for in-patients (excluding the newborn) and $2.00 per visit for outpatients.

[26] In Ontario enrolment is compulsory for people employed by organizations of 15 or more employees and on application for people in organizations of between 6 and 14 employees. Others may apply directly and pay individual or family premiums quarterly. About 97.3 per cent of the eligible population were estimated to be covered in February, 1963.

In Prince Edward Island, enrolment is compulsory for people in organizations with two or more employees. Others may enrol and pay premiums directly. Almost all eligible persons are enrolled.

[27] K. C. Charron, "The Hospital Insurance and Diagnostic Services Program in Canada," paper presented at the School of Hygiene, University of Toronto, February, 1962.

ported, medical care programmes for special groups, such as deep-sea mariners, Indians and Eskimos, the R.C.M.P., members of the armed forces, and veterans.[28] For some of these programmes it maintains hospitals, nursing stations, and clinics; for others, it reimburses provincial hospital plans and practicing physicians for services.

PROVINCIAL PROGRAMMES

Workmen's Compensation. In all provinces, public boards administer a system of cash compensation for loss of income, permanent disability pensions, full medical, hospital, drug, and restorative care, widows' pensions, dependent children's pensions, and burial benefits for workmen injured or ill as a result of their employment. Board decisions are for practical purposes not subject to judicial appeal.

Medical factors are stressed in making any decisions. The legal adversary system and private insurance agencies are not involved. Extensive social rehabilitation and job placement services are provided also. Almost all classes of industrial and, in most provinces, business and retail employees are compulsorily covered. Employers, farmers and certain others may enrol voluntarily.

Revenues are obtained from a graded assessment on employers, based on the cost experience of each class of industry. The injured workman contributes indirectly by a waiting period of three to seven days before he receives compensation. There is no waiting period for medical care. Initial free choice of physician is allowed but specialist care may be required for certain cases. Physicians are paid on a fee-for-service basis which approximates the provincial medical association tariffs.

[28] Approximately 425,000 people are covered for complete health care services under these programmes. Some 190,000 veterans receive care for service-related disabilities. About 500,000 veterans are eligible for services at cost for non-service related illness.

[29] In most areas the taxes are $5.00 per year for a single person and $10.00 per year for a family; in parts of these wealthier areas the premiums range between $8.00–$12.00 per year for a single person and $16.00–$24.00 per year for a family.

The Newfoundland Cottage Hospital and Medical Care Plan. In 1935, the Cottage Hospital and Medical Care Plan was started for people in the outports. Hospitalization is now covered under the provincial hospital plan. Home, out-patient care and in-hospital physicians' services are provided for some 200,000 people, through hospitals, nursing stations, a travelling sea clinic, and an air ambulance service. The hospital and district physicians receive most of their incomes from salaries.

Small annual premiums cover part of the cost.[29] Additional charges may be made for maternity care, dental extractions, out-patient drugs and appliances at set rates. The patient pays transportation costs unless certified as unable to pay. The majority of revenues come from general taxes.

Government help is given also to the International Grenfell Association which operates a chain of hospitals, nursing stations, and a boat clinic service in Labrador and on the west coast of Newfoundland.

The Newfoundland Children's Health Service. In 1957, a tax-supported programme was started to cover children under 16 years of age (approximately 175,000) for in-patient hospital diagnostic and standard ward care and for out-patient diagnostic services, excluding medical care. In 1958, in-patient medical and surgical services were added and hospital care was included under the provincial hospital plan.

Saskatchewan Medical Care Insurance Plan. Socio-economic circumstances during the years of settlement, the depression of the 1930's, and years of drought have stimulated collective approaches to solving difficulties. Municipal doctor plans, under which a municipality employed a doctor, were numerous. Union hospitals, built by groups of municipalities, have been a major form of hospital development. In 1944, the Cooperative Commonwealth Federation, a moderate Socialist party, was elected. A provincial hospital insurance plan was begun in 1947. Encouragement and some financial support was given to the Swift Current Medical Care Plan, a regionally operated medical insur-

ance plan, after 1946.[30] Saskatchewan was one of the first provinces to sign an agreement under the Dominion-Provincial Hospital Insurance Programme.

In 1959 an Advisory Planning Committee on Medical Care was announced,[31] to recommend methods for developing a medical care programme to be based on prepayment, universal coverage, high quality of service, government sponsorship, and a form acceptable both to those providing service and to those receiving it. The Saskatchewan College of Physicians and Surgeons[32] in October, 1959, passed a resolution opposing a government programme. Tensions mounted during the election campaign in June, 1960. The Government was returned with a reduced majority.

Almost all briefs submitted to the Advisory Committee strongly supported the positions of either the Government or the College or were concerned largely with special problems, for example, mental health. The College and its supporters opposed a compulsory, government plan and favoured subsidization by government of non-government plans for enrolment of the aged and other "high risk" groups. The Saskatchewan Labour Federation, on the other hand, favoured a comprehensive government plan with payment of doctors by salary, possibly including a capitation component.

An interim majority report recommending a comprehensive medical care plan administered by a public commission was submitted in September, 1961.[33] Payment of the doctors would be on an agreed fee-for-service basis. A minority report by the representatives of the College of Physicians and Surgeons and the Saskatchewan Chamber of Commerce representative supported the proposals of the College brief. A dissenting statement by the representative of the Saskatchewan Federation of Labour agreed in general with the majority report but recommended a comprehensive, tax-supported, and salaried service.

In November, 1961, the legislature passed the Saskatchewan Medical Care Insurance Act.[34] The plan would provide comprehensive physicians' services. It would be administered by the Saskatchewan Medical Care Commission, including at least two doctors out of six to eight members. An advisory Council representing professional and public organizations and a Medical Advisory Committee would be appointed. Premiums would be paid by all residents,[35] other than dependents and indigents. The remainder of the revenue would come from sales and other tax sources. The estimated aggregate cost for the first year would be in the order of $23.00 per capita.[36] The College at its annual meeting voted almost unanimously to reject the proposed plan. The Minister asked the College for nominees to the Commission. On being refused, he appointed two doctors known to be Government supporters. The College was asked for advice on the fee-for-service payment system. When no reply was received, it was announced that the rate and schedule used by the medically-sponsored plans would be followed.

Attempts at conciliation failed. Various organized pressure groups were formed and mass meetings were held. The College demanded that the Act be withdrawn. The Government replied that no democratic gov-

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[30] Supported by local tax assessments. Doctors were paid on an agreed fee-for-service basis. Deterrent charges were made on office, home, night, and weekend calls.

[31] Consisting of three representatives named by the College of Physicians and Surgeons of Saskatchewan, three government representatives, three representatives of the general public, and one representative each of the University of Saskatchewan College of Medicine, the Saskatchewan Chamber of Commerce, and the Saskatchewan Federation of Labour.

[32] Unlike almost all other provinces where the licensing, disciplinary, and other statutory professional functions are vested in provincial Colleges of Physicians and Surgeons but the socio-economic activities are carried on by separate provincial medical associations, in Saskatchewan both are carried out by the College.

[33] Saskatchewan. Advisory Planning Committee on Medical Care to the Government of Saskatchewan, *Interim Report* (Regina: Queen's Printer, September, 1961, pp. 121).

[34] Saskatchewan. *The Saskatchewan Medical Care Insurance Act, 1961 and Amendments.*

[35] Single person—$12.00 per year; family—$24.00 per year. Collected with the hospitalization tax.

[36] *Op cit.*, pp. 74–86. As of April, 1963, costs are reported as within the estimate.

ernment could give up its legislative rights to any group. The Act went into effect on July 1, 1962, and the majority of doctors, except in some remote and rural areas, closed their offices. Free emergency services were provided through designated hospitals by the doctors. The Commission brought in doctors from elsewhere and several community clinics with doctors willing to work under the Act were formed.

In June, the Government had said it was willing to have mediation. Support for the idea grew. The President of the College in July no longer asked for withdrawal of the Act but said doctors should be free to practice outside it and that beneficiaries should be free to assign the right of collection to any insuring agency as an intermediary with the Government. The Government asked Lord Taylor, a prominent British doctor, to come as their adviser. On July 23, through his efforts, a compromise was reached. A beneficiary must pay his premium but he may now choose one of four methods for obtaining care:

1) He may go to a doctor willing to bill the Commission directly. Some doctors, particularly in community clinics, are doing so.

2) He may enrol with one of two medically-sponsored prepayment agencies or with the combined insurance company agency. The doctor bills the agency which in turn sends his account to the Commission. It assesses the account and sends payment to the agency, which in turn pays the doctor. In order to encourage enrolment with the agencies, many doctors accept a small discount to cover administrative expenses involved. Most doctors are working under this arrangement.

3) The patient may pay the doctor directly and receive a receipted and itemized account. He submits it to the Commission and is reimbursed to an agreed level.

4) The patient and doctor may agree to make the transaction a purely private one.

Frictions continue over such matters as agency billing procedures, Commission payments to the agencies, and the continuing development of community clinics which provide capital facilities for doctors willing to bill the Commission directly. Approximately 110 doctors, including a high proportion of specialists, were estimated to have left by early 1963. Others have come. As of January, government estimates placed the net loss at approximately 25. An interesting recent development has been the return of almost full autonomy to the Swift Current Regional Health Board for operating its programme. The final report of the Advisory Committee, submitted in September, 1962, contains data on health service patterns, resources, and needs and recommendations for future developments.[37]

Provincial Public Assistance Programmes. In British Columbia, Alberta, Saskatchewan, Ontario, and Nova Scotia, special provincial programmes to provide payment for certain medical services[38] for some or all social assistance recipients have been established. Three are operated by agencies set up by provincial medical associations and two directly by the provinces.

In Newfoundland, indigents are covered under the Cottage Hospital and Medical Care Plan; elsewhere either payment is made by the province or public clinic facilities are available. Manitoba provides extensive

(*Continued on page 368*)

[37] Saskatchewan, Advisory Planning Committee on Medical Care to the Government of Saskatchewan, *Final Report* (Regina), Queen's Printer, September, 1962, pp. 270.

[38] Home and office calls in all and in some, certain drugs.

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Sweden's health program is "an expression of the resolve, apparently shared by the great majority of the Swedes, that even if medical care is expensive and means large demands upon the public purse, it must be provided for those who need it without adding more than is absolutely essential to the cost to the individual. . . ."

Socialized Medicine in Sweden

By JOHN H. WUORINEN
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THE PRESENT compulsory health insurance program in Sweden, of which medical care is a part, was originally enacted in 1946. It is thus only 17 years old. Some of its features were revised as recently as 1961. The whole system, however, rests upon foundations laid 50 and more years ago. The broad base of the system was the national pensioning scheme established by the National Pensions Act of 1913. The Act covered the whole population. Its main feature was compulsory old-age and invalidity insurance. It provided for a life annuity, the size of which was determined by the size of the contributions made, and for a supplementary pension paid out of public funds. The amount of the pension was determined by need. A means test was thus a part of the program.

NATIONAL PENSIONS ACT REVISED

The law was revised in 1935 and again in 1946. While the revision of 1946 introduced important reforms of the pension scheme both as to scope and amount of benefits, it too underwent change in the course of the next dozen years and more. A significant improvement in 1959 tied benefits to the cost-of-living index. This means that changes in prices do not affect the value of the benefits; pensioners are enabled to avoid the consequences of inflation. The device used is a standard supplementary payment, calculated by means of "pension points" which guarantee a constant pension value.

GRADUAL SOCIALIZATION

In view of the fact that the Social Democratic party has been in power during the past generation, the role of Socialist Labor in the evolution of the Swedish system of social services invites passing mention. Ever since the founding of the "Social Democratic Workers' Party of Sweden" in 1889, its program and leadership have been rather far removed from the commitment to radicalism that socialism generally represented before World War I. To be sure, while the Socialist program (put forth in 1897) aimed at a fundamental change in the economic organization of "bourgeoisie" society, it did not slavishly follow radical Marxist theorizing. Gradual socialization and not cataclysmic revolutionary upheaval was to mark the road leading to the promised land. The more radically inclined ultimately found, after 1918, a congenial home in the Communist camp.

In recent decades a further change in position and objectives has emerged. The effort to build a better world by achieving socialization appears largely to have been abandoned. Transfer of privately owned means of production into means of production owned and

managed by the public has no longer been put forth as a Socialist must. The accent has come to be placed, instead, on a different approach and a different program.

The program and the theorizing that furnishes its ideological basis have long since come to be shared by many if not most non-Socialist Swedes. Most Swedes appear to favor the establishment of an order of things in which the more obvious inequalities of wealth and class distinctions have been wiped out, or at least greatly reduced, by a broad program of social services. These social services, made possible by a more equitable utilization of the taxable resources of the nation, are seen as speeding the emergence of a freer and more egalitarian society. By placing within the reach of lowly, anonymous Everyman the essentials of a more secure, healthier and longer life, he is raised to levels previously tenanted only by the well-to-do and the well-born, and society as a whole is brought closer to the democratic ideal in degree as the welfare of the individual citizen becomes the deliberate aim of the social program and activity of the State.

THE HEALTH INSURANCE PROGRAM

The health insurance provisions fall at present into two groups. The first provides for medical care benefit insurance, and the second, sickness benefit insurance. Medical care covers, for all practical purposes, all of the Swedish people. The sickness benefit insurance does not. It covers only those members of the sickness fund whose annual income from gainful occupation is at least 1,200 crowns (or $240; 1 crown is the equivalent of about 20 cents). Married women and other women with children under 16 years of age, without reference to a specific annual income, are also covered.

The sickness fund members, when ill, receive a basic sickness benefit of 3 crowns (60 cents) a day. Wage earners whose income is 1,800 crowns a year or more, receive a supplementary or additional sickness benefit that varies from 1 to 17 crowns (20 cents to $3.40) per day, depending on the size of the income.

Benefits, except basic coverage, are thus proportional to income. The higher the income, the higher the sickness benefit: the maximum daily payment of 20 crowns ($5.00) goes to individuals whose annual income from employment is 14,000 crowns or more ($2,800 and up). The benefits are not paid for the first three days of illness and are reduced after 180 days of illness for all but the lowest income groups. Allowances for hospital treatment are paid for a maximum of 730 days for each illness. The usual maxima, however, appear to range from 90 to 180 days.

The chronically ill present a special problem. Regarding this, K. G. Michanek, Chief of the Information Service of the National Social Insurance Office, pointed out last year that health insurance and pensions "are now being forged into a unified system which applies both to the basic and the supplementary benefits." This will mean that "the chronically ill will be automatically transferred from health insurance to the pensions scheme and receive the pre-retirement pension after a certain period." Permanent disability will mean, without reference to age, a pension equal to the regular retirement pension.[1]

Medical benefits include medicines at a reduced price (or free of charge if the recipient is on relief; such cases require a means test). Allowances for medical treatment are at least one-quarter of the doctor's consultation fee and may run to 75 per cent of the fee. The cost of getting an injured person to the doctor above .80 cents–$1.00 is covered by the allowance, and the same applies to the return from the doctor. Hospital treatment allowances correspond to the fees charged in a general ward (approximately $1.00 per day); "remaining costs are covered by hospital administration out of tax funds."[2]

Closely connected with these medical and sickness benefits are allowances for childbirth

[1] K. G. Michanek, *Social Insurance in Sweden* (1962), pp. 4–7.

[2] Konrad Persson, *Social Welfare in Sweden* (1961) p. 37.

expenses, a general maternity grant—the basic grant is 270 crowns for the first child and 405 crowns "for more than one child"—and the costs covered by the Industrial Injuries Insurance Act that provides for doctor's care, hospitalization, medicine and so forth for victims of industrial injuries. The same is true of "social assistance," a new term that has emerged as a substitute for the harsher "poor relief" of earlier days. Social assistance involves a means test. The area within which social assistance remains important is gradually contracting because of the expanded and improved system of general social insurance. The indications are that social assistance will before long go the way of the poor house—will, in other words, become one of the many unmourned historical curiosa of a past age.

PUBLIC DENTAL SERVICE

The Public Dental Health Service is one of the important features of the general program of health care. It rests upon experience recorded over several decades. A dental clinic for persons of small means was set up in Stockholm as early as 1865 and another in Gottenburg in 1883. After the turn of the century, extensive surveys of the condition of teeth among school children disclosed the need for remedial action and led, in 1904, to the raising of the question in the Riksdag of the need for and advantages of a dental health service maintained by local public authority.

While nothing came of the 1904 Riksdag discussion the subject, once raised, would not down. It was investigated by various commissions between 1917 and 1937. Meanwhile, school dental services had been set up in various localities, on the initiative of local authorities, dental societies and other interested organizations. Important pioneering services in this field were begun in 1906, 1907 and 1908, Stockholm and Gothenburg being among the cities that led the procession. A Royal Commission's recommendations were accepted by the Riksdag in 1938 and led to the establishment of the national dental health service which went into effect in 1939. By that time, incidentally, most Swedish cities and some rural communities had gathered substantial experience in operating school dental services. The dental needs of adults also had received some attention. Stockholm, for instance, had established dental clinics for persons of limited means. The dental health service launched in 1939 has understandably undergone reorganization over the years in degree as experience has indicated the need of change. The present organization, based upon a Royal Commission recommendation, went into effect on July 1, 1961.

An estimate in 1948 showed that a complete dental service would require some 2,500 dentists employed by the Service. In 1960, the estimate was revised upward to 4,000. By July, 1961, the Service employed 1,812 dentists. (The total number of dentists in Sweden in 1961 was about 5,100.) In the preceding year the number of patients who received "full dental treatment" was 946,850, while "partial treatment" cases came to 345,200. Children in the 7–15 age category represented 64.7 per cent of the population in this age group. One-third of the 6 year-olds received treatment. It has been estimated that about 80 per cent of the children aged 7 to 15 get their dental treatment through the Service or the municipal care programs and clinics.

An unmistakable indication of the trend since the Service began in 1939 is given by the fact that it had, in 1940, 34 district dental clinics and one central clinic. In 1961, the figures were: 751 district clinics, 22 central clinics, 45 branch clinics and 30 orthodontic clinics.

Meantime more ambitious programs are emerging or contemplated. This is underlined by the supplementary service pension scheme, effective during the past two years, which provides for expanding benefits. The Swedish Information Service in New York put the matter in this way, under the date January 24, 1963:

> At the end of 1963 only some 50,000 citizens, born in 1896 and thus reaching the age of 67, will be receiving service pensions, and the maxi-

mum total payment this year will be 1,833 kronor, or about $355. The pensions as well as the number of beneficiaries will then increase gradually. The first full rates will be reached in 1981, when those born in 1914 will be able to draw up to 18,330 kronor, or $3,540, plus compensation for price increases. The number of people who will receive service pensions in 1981 is estimated at some 1,100,000. Not until the turn of the century, however, will the full rates be applied to all who have reached the retirement age.

The service pension scheme also covers widows and children and there are special provisions concerning disability. In some exceptional cases the maximum annual pension of 18,330 kronor may actually be paid out this year, namely, to citizens who in 1962 as a result of accident or illness became almost totally disabled and who from the beginning in 1960 belonged to the service pension scheme in the highest income bracket. Under similar conditions widows may this year get 7,332 kronor, or $1,415. The highest annual pension for children under the service pension system will be 1,833 kronor, or $355.

Another indication of the trend is given by a new plan offering additional medical service and specialized treatment. It was presented to the government by the Swedish Medical Association last February (1963). It calls for expanded and improved outpatient care with the establishment of a network of privately managed "medical houses" or health stations. Forty of the proposed health stations or centers are to be built at once. It is expected that 75 per cent of the population will be covered by these new outpatient centers by 1970. The centers will be built and equipped by the Medical Association—one such center has operated not far from Stockholm since 1956—cooperating, at least in part, with municipal authorities. It is expected that the centers will ease the pressure on hospitals and lower the cost of caring for certain groups of patients.

ADMINISTRATION OF THE PROGRAM

Medical care benefits come under the general administration of the health insurance program. The general program and its subordinate parts rest upon the National Health Insurance Act of 1946. It called for a compulsory scheme which superseded the earlier voluntary insurance set-up. The law was revised in 1953, and the modified program went into effect in 1955. Further revision of the law in 1961 abolished, as of January 1, 1962, local sickness funds and provided that health insurance would be administered instead through the larger county or municipal units. At the top level, the National Pensions Board and the previously separate National Insurance Office were merged into a single directing government agency, the Social Insurance Board.

Local administration of the elaborate system—especially in pension matters—unavoidably involves rulings that some beneficiaries of the system consider unfair or wrong. The law in effect since 1961 provides that local rulings can be taken on appeal to the Social Insurance Board. Appeals against the decisions of the Board can be submitted for review, not to the Government as had been the case before 1961, but to a special newly established Social Insurance Court.

The authority responsible for the supervision of the Dental Health Service is the National Board of Health (which comes under the Ministry of the Interior). The actual organizing and functions performed under the Service are the responsibility of county and urban councils. Within each area a "dental inspector" is the supervising agent and head of the Dental Health Service in the locality. Each district has at least one District Dental Clinic and employs dentists, the number varying according to the number of children in the district (some 500–600 children per dentist). In addition to ordinary dental treatment, special care is also provided in clinics connected with certain hospitals.

COSTS OF THE PLAN

The general health insurance costs are not fully met by public outlay, national or local. Since 1955, when the present compulsory insurance law went into effect, approximately 50 per cent of the cost has been covered by individual premium payments, 25 per cent by contributions coming from the employer, and 25 per cent by the public treasury which means, obviously, by taxpayers. Referring

TABLE I. NET COSTS OF MEDICAL CARE
(Millions of Crowns)

	Government	Rural Councils	Urban Councils	Other Local Authorities	TOTAL
1928	28	36	18	—	82
1948	237	244	112	16	609
1954	507	544	229	21	1,299
1956	679	677	289	21	1,666

to this distribution of costs, Karl J. Hojer, former Director of Sweden's Royal Social Board, stated in 1959 that by the early 1950's it had become clear "that direct taxes in Sweden had become so high, especially on upper incomes, that any attempt to apply further pressure would have dangerous effects." A situation "had been reached where a transfer by taxation of money from the higher income groups to the lower income groups, in the form of social benefits for the latter, could not be pursued any further."

"On the other hand," Mr. Hojer continued, "the income of the mass of the people had risen so sharply that it was no longer unthinkable but on the contrary beneficial to let them bear the burden themselves for the improvement of social benefits." This view prevailed when the law of 1955 was prepared, with the result that individuals' payments were increased while the state's share in the costs was reduced.[3]

An official estimate in 1954 by the Minister of the Interior indicated that the total of Sweden's direct and indirect costs of sickness came to 4 billion crowns or about $800 million annually. This figure included, however, costs not covered by national or local appropriations. "Net expenses," which include the sums paid by public authorities for medical care and various health measures, were formidable enough, as the figures for 1928–1956 show. See Table I.

In 1958 the State outlays for health and medical care were 662 million crowns, while the cost of these services to local authorities came to 1,022 billion crowns, the total thus being about 18 million above the 1956 figure. "Local authorities spend welfare money mostly on health and medical care. . . ."[4] The total cost of all social services in 1958 came to 6,617,000,000 crowns, or approximately 14 per cent of the total national income for the year (in 1950, the percentage was 10.6).

The costs of the dental service are, on the whole, more easily ascertained. That they are considerable and will increase in degree as larger numbers are treated is clear. In 1958 the costs came to about $17.5 million, in 1959 to $19.5 million and in 1960 to $21 million. These figures do not include the costs of maintaining premises and so on which are met by local authorities. Children are treated free; adults pay a modest fixed fee. Rural councils receive a subsidy from the national treasury of $3.00 for each child treated and urban councils one half of that amount.

The real costs of the medical care program are more difficult to determine than a casual glance at the facts might suggest. One reason for the difficulty is that all medical schools and nearly all hospitals in Sweden are owned and operated by public authorities, local, district or national. They are very efficiently run. The service they render is given at low cost, at times at amazingly low

[3] *Scandinavia, Past and Present* (1959) vol. III, p. 175.

[4] Official figures available to the writer are in part contradictory. The figures given above are from Konrad Persson's work cited above, pp. 49–50. On p. 48, however, expenditures for "sickness" in 1958 are given as 2,489 million crowns which "includes outlays for national health insurance and corresponding services to the amount of almost 1,057 million crowns." Mr. Persson is the Director-General of the National Pension Board in Stockholm.

cost. Practically all the outlay is met by public funds. The whole system is an expression of the resolve, apparently shared by the great majority of the Swedes, that even if medical care is expensive and means large demands upon the public purse, it must be provided for those who need it without adding more than is absolutely essential to the cost to the individual—considerable in any case—of being ill.

WHAT OF THE FUTURE?

In contemplating future changes in Sweden's medical care and general social service benefits one conclusion seems clearly to emerge. The conclusion is that the rate of improvement will in all likelihood slow down. The reasons for the slowdown appear obvious.

The cost of the general social welfare program, and that of medical care in its various forms, falls directly or indirectly upon the gainfully employed groups. The individuals who comprise these groups are in the last analysis the only source of the funds that must be raised, by whatever forms of taxation are deemed best, to pay for medical and other aid. To determine the foreseable size of this element in the population and to calculate its capacity for carrying the cost burden in the future are therefore not only revelant but essential for an understanding of the problem during the years that lie ahead.

This is merely one way of saying that the ratio of productive to non-productive members in the population is a decisive factor. In terms of age groups, the components of the future population of Sweden are therefore significant. A glance at the population pyramid in the late 1950's and the projected age pyramid of 1970 and 1980 indicates the basic facts involved. Omitting non-essential details we find that while in 1957 seven Swedes belonged in the productive group for every Swede old enough—67 years—to receive old age pension payments, the figure will be between five and six in 1970 and smaller still in 1980.

THE AGED

To note that the old people in Sweden as elsewhere are especially in need of medical and other services is to state the obvious. Their numbers have grown at an impressive rate. The reason is that the Swedes live much longer than formerly. The average length of life for Swedish males in 1900 was 55 years and in 1955 a fraction over 70 years; the corresponding figures for women were 57 and 73 years. That the old occupy relatively many beds in hospitals, figure prominently in out-patient care programs and create the need for nursing and rest homes is part of the picture.

The extent to which the older, pension-age population may represent usable capacity for productive work has as yet been only moderately explored. That capacity will have to be measured and utilized in order not to leave untapped a resource that might turn out to be of considerable importance. This is turn seems logically to point to an adjustment of social welfare effort to rehabilitation programs designed to capture, to the greatest possible extent, the latent productive abilities of the aged.

Only effective rehabilitation programs can be expected to make it possible for a substantial part of the oldsters, now set aside as passive consumers from the working force of the nation, to re-enter the ranks of productive citizens. As additional working citizens they can contribute to the resources which alone, in the long run, can nourish a viable social welfare system of the high standard Sweden has erected during the past quarter century.

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"The ready access to medical care, the absence of financial worry for the ill, and the expectation of adequate care as a right, are all undeniably attractive features of the system for Soviet citizens."

Medical Care in the Soviet Union

By Alvin Z. Rubinstein
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On October 31, 1961, the Twenty-second Congress of the Communist Party of the Soviet Union adopted a new Party program—the first since 1919—which stated that "The Party solemnly proclaims: the present generation of Soviet people shall live under communism!" The Party program sought to convince the Soviet people that the attainment of communism was no longer a utopian vision, but an attainable goal within a generation. Among other things, it promised the extension and improvement of welfare state benefits, especially in the fields of health services and medical care:

> The Socialist state is the only state which undertakes to protect and continuously improve the health of the whole population. This is provided for by a system of socio-economic and medical measures. There will be an extensive program designed to prevent and sharply reduce diseases, wipe out infectious diseases, and further increase longevity. The needs of the urban and rural population in all forms of highly qualified medical services will be met in full. This calls for the extensive building of medical institutions including hospitals with sanatoria, the equipment of all medical institutions with modern appliances, and regular medical check-ups for the entire population. . . . In addition to the existing free medical services, accommodation of sick persons at sanatoria and the dispensing of medicines will become gratuitous.

The Soviet regime has committed itself to providing ultimately "free medical services for all citizens, including the supply of medicines and the treatment of sick persons at sanatoria." The provision of medical care in the Soviet Union is acknowledged to be a responsibility of government.

Observers of the Soviet scene generally agree that, even among Soviet citizens who bitterly resent the harshness and controls of the system, there is widespread endorsement of the welfare measures promoted by the Government. According to one study, which was based largely on interviews with Soviet refugees, "Certain features of Soviet society win strong, widespread support and approval. These are notably the welfare-state aspects of the system, such as the health services, government support of the arts, and public educational facilities."[1] Before delving into the operation and organization of medicine in the U.S.S.R., a few words are in order about Czarist antecedents.

Russia under the Czars was technologically and scientifically a backward country. Though there were individual scientists of eminence, in general science and medicine lagged far behind Western Europe. With the abolition of serfdom in 1861, Czar Alexander II introduced the *zemstvo* or local governmental assembly which began to assume responsibility for the establishment and operation of health services in the rural areas among its other political and administrative

[1] R. A. Bauer, A. Inkeles, and C. Kluckhohn, *How The Soviet System Works* (Cambridge: Harvard University Press, 1956, p. 214).

functions. Efforts at reform were slow, inadequate, poorly financed. Low on the list of priorities designed to modernize Russia, they touched but a fraction of the population. Doctors were few, hospitals were ill-equipped, and medical training facilities were in their infancy. Centuries of peasant superstition and ignorance had also to be overcome. However inadequate, the *zemstvo* program did represent the first serious step to provide medical care for the rural population.

Medical advances occurred in the latter half of the nineteenth century, due largely to the brilliant work of men such as Nikolai I. Pirogov (1810–1881), Ivan M. Sechenov (1825–1905), and Elie Mechnikov (1845–1916). Pirogov was instrumental in establishing in 1877 the Society of Russian Physicians which actively pressed for extensive reforms and frequently criticized the Czarist government. The Pirogovists, as members were commonly called, made the medical profession a potent social force until they were undermined and reorganized by the Bolshevik regime. The best-known Russian medical scientist at the time of the 1917 Bolshevik Revolution was Ivan P. Pavlov (1849–1936), whose experiments with conditioned reflexes brought him universal acclaim. But, in general, on the eve of the revolution, medicine and medical care were at a low level of development. The overwhelming mass of the population had no medical care, infant mortality was high, and contagious diseases were widespread.

EARLY SOVIET EFFORTS

At the time of the Bolshevik Revolution, Russia was experiencing a pervasive economic, social, and military breakdown. Food was in short supply, the transportation system was in chaos, and the rudiments of social order were sorely weakened. Against this background, health and sanitation conditions deteriorated alarmingly. Epidemics threatened to sweep the country. At the height of the crisis, Lenin declared that "Either the louse defeats socialism or socialism defeats the louse."

In July, 1918, the Soviet regime established a Ministry of Public Health which was given the responsibility for planning and operating the nation's medical program. The Ministry's immediate task was to cope with the epidemics of typhus and cholera. During the period of "War Communism" (1917–1921) emergency measures predominated and the medical profession was, to all practical purposes, nationalized. A degree of relaxation took place between 1921 and 1928, at the time of the N.E.P. period, when private practice was again permitted. This was a period of partial return to free enterprise in agriculture, trade, and some light industry. The Government undertook the development of medical facilities, the training of new physicians, and the improvement of standards of preventive medicine.

In late 1928, Stalin emerged triumphant from the intra-Party struggle for power and embarked on a crash program of rapid heavy industrialization and forced collectivization of agriculture. He set out to transform Russia from an economically underdeveloped country into a major industrial state. All institutions, organizations, and professions now came under the harsh, strict control of the Government. Along with the labor unions, farms, factories, schools, and cultural organizations, the medical profession was nationalized and all physicians became employees of the Government. New medical institutes trained thousands of physicians and medical technicians, all employees of the Government. Repeated curriculum revisions were introduced into medical schools, as the regime sought to establish a satisfactory balance between theoretical and practical subjects, between general practitioners and specialists.

1936 CONSTITUTION

Article 120 of the 1936 Soviet Constitution sets forth the following guarantees to all citizens:

> Citizens of the U.S.S.R. have the right to maintenance in old age and also in case of sickness or disability.
>
> This right is ensured by the extensive develop-

ment of social insurance of industrial, office, and professional workers at state expense, free medical service for the working people, and the provision of a wide network of health resorts for the use of the working people.

How is this provision carried out in practice?

Health services are organized to meet the requirements of a society in which political and economic power are concentrated in the hands of the State and the leadership is committed to the long-run objective of building communism. The comprehensive system of medical care for the population is administered through a complex, hierarchical network of institutional forms. These embrace all aspects of medicine and reach into every area of the country. According to a 1960 study by the World Health Organization "the basic principle of this structure is highly centralized planning and supervision, coupled with almost complete executive and operational decentralization, permitting almost 90 per cent of problems to be dealt with at local levels, without disturbing the general and basic pattern in any way."

ADMINISTRATION

The administrative structure of health services is comprised of six functional groups[2]: 1) Responsibility for over-all planning and supervision is vested in the Ministry of Health for the U.S.S.R., and the separate Ministries of Health for each of the 15 union-republics; 2) Research is coordinated by and conducted under the auspices of the Academy of Medical Sciences, located in Moscow; 3) Various scientific councils are attached to the Ministries of Health in order to advise "the Ministries in regard to the adoption of methods of work and the introduction of new developments in medical science"; 4) All medical education is controlled by the Ministry of Health; 5) Health Departments are set up at the city, district, and regional levels and are responsible for the executive-administrative supervision of the local establishment; and 6) The actual hospitals and clinics are organized into a series of health districts which are usually based on population.

The most significant fact about the system of medical care in the Soviet Union is that it is a function of government. All medical, dental, and public health services are carried on through the Ministry of Health in each of the 15 union-republics. The cities and rural areas are organized into districts. Each district has a hospital or clinic which "offers comprehensive and integrated health care, both for in-patients and for out-patients."[3] Medical centers serve the adult population. These vary in size and degree of specialization. A patient in need of treatment goes to the polyclinic in his district, receives such examinations as are necessary, and is directed to a specialist, if this is required. Consultations are free, as are the surgical or hospital care that may be necessary.

The district hospital is also responsible for the medical well-being of the entire population, and for the follow-up treatment and checks on local health conditions. It handles "environmental sanitation and epidemiological control of communicable diseases in the area, through a network of sanitary and epidemiological stations." District hospitals are supposed to be available in sufficient numbers to serve a population of 70,000 to 150,000. However, it is probable that the urban dweller has better facilities, more readily accessible, than the 45 per cent of the population who live in backward rural areas.

IMPROVEMENT IN CARE

There is no doubt that the medical care available to the average citizen has improved considerably in recent decades. The Soviet Union boasts that it has the largest number of doctors per 10,000 inhabitants in the world, approximately 16 doctors for each 10,000 persons. Further, the number of doctors being trained far exceeds that of any Western country. Thus, whereas in 1913, there were approximately 20,000 physicians in Russia, in 1957, there were more than 360,000, and the target for 1965 is 490,000. Approximately

[2] Public Health Papers No. 3, "Health Services in the USSR" (Geneva: World Health Organization, 1960, p. 10).

[3] *Ibid.*, p. 11.

70 per cent of the physicians happen to be women.

State expenditures on health services have continued to increase, doubling in the decade between 1951 and 1961. All medical services are available free of charge, though patients must pay for drugs and medicines. All medical schools, medical institutes, hospitals, and sanatoria are also owned and operated by the Government. As with most welfare services, the financing of these benefits comes from general taxation. Approximately six per cent of the total national budget is spent on national health services, i.e., in 1959, 44 billion out of a total of 704 billion rubles (these figures are for old rubles; in 1961, the ruble was revalued at the rate of ten old rubles for one new ruble); in 1963, about 5.5 billion out of a total of 86.1 billion (new) rubles were allocated for health services.

The Soviets place great emphasis upon preventive medicine. To this end, they have established an elaborate program of maternal and child health services (M.C.H.). This attention to the health of women is of particular importance in a society where it is usual for women to work full-time, often in strenuous occupations.

Expectant mothers are given paid leaves and exemptions from arduous work in the period immediately before and after the pregnancy and confinement leave. In 1956, the Government extended the period of leave to 112 days, 56 days before the birth and 56 days after. "Once pregnancy has been confirmed a woman may not be dismissed from her employment, and during her maternity leave the undertaking for which she works must pay her full salary. If her post-partum leave is extended she continues to draw her salary for three months from the date of birth. She may then prolong her absence from work for a further nine months without losing her job, but not being paid."[4]

[4] Public Health Papers No. 11, "Maternal and Child Health in the USSR" (Geneva: World Health Organization, 1962, pp. 17–18).

[5] Leona Baumgartner, "A Doctor Diagnoses Soviet Medicine," *The New York Times Magazine* (May 17, 1959), p. 46.

CHILD HEALTH

Children are given careful attention; and Soviet medical schools are graduating an estimated 3,000 pediatricians every year to cope with the growing population. To encourage mothers to work, and at the same time to safeguard the health of its children (some believe it is to indoctrinate pre-school age children in Communist ideology), the Government has established thousands of nurseries, though these are not enough to meet the existing demand. Children under three years of age may be placed in creches if the mother works or is a student. The creches are open six days a week and may keep the children for any part of the day. Children between the ages of three to seven may be placed in kindergartens which are also numerous, but, as with the creches, not nearly sufficient to meet the heavy demand. Approximately three million children are cared for in kindergartens.

Visitors to Soviet pre-school nurseries generally come away impressed with the attention and tenderness that the children receive. One American doctor noted:

> The very young children in these nurseries seemed remarkably healthy and happy—so much so that one wonders if the almost universal opposition to this practice in the United States should be reexamined.[5]

Soviet children start primary school at age seven. Their health is kept under close supervision by school physicians. Since the number of physicians is still inadequate to meet existing needs, medical technicians perform a considerable portion of this kind of work.

There is, of course, no way of determining, with any certainty, the degree to which legislative provisions and governmental benefits are carried out in practice. Yet it seems clear that the regime has been moving in the direction of more systematic and comprehensive services. According to Professor Mark G. Field, a leading American authority on Soviet medicine and medical care, the Soviet blueprint for socialized medicine works and is, incidentally, "especially germane to

the needs of the economically underdeveloped countries."

> Soviet success in increasing the supply of physicians, in eradicating certain diseases and mitigating the impact of others; the expansion of medical facilities in the countryside; the lowering of infant mortality and lengthening of life-expectancy at birth—these are undeniable achievements of Soviet medicine. They are successes which derive from the quantitative application of generally available medical knowledge, rather than from pioneering advances in medical research and its qualitative clinical application. Under Soviet conditions, such an approach makes eminent sense.[6]

DIFFERENCE IN STANDARDS

American doctors and health officials have frequently pointed out the differences in standards between Soviet medical programs and those in the West. For example, one United States Public Health Mission, which visited the Soviet Union in 1957, reported that:

> The Mission found great divergence in medical facilities and in the quality of medical training. Almost everywhere, facilities were overcrowded; in several medical institutes there was a lack of proper working facilities, especially in the basic or preclinical sciences. . . .
>
> . . . The Soviet facilities were sufficient for demonstrations or examination of fixed materials, with heavy emphasis on museum material, microscopic slides, etc. Teaching appeared to be largely by demonstration rather than by student participation. . . .
>
> In many places, Soviet medical laboratory equipment was found to be antiquated. Training, research, and practice are fractionated and compartmentalized. The concept of the "university" climate as the essential broadening influence requisite for the development of first-rate physicians has been abandoned in favor of average training at the level of an average rank-and-file medical artisan.[7]

The difference in standards is also greatly in evidence when one reviews the medical care given to the rural population. Despite obvious progress, the regime has not been able to supply sufficient physicians for the rural population and continues, as in Czarist days, to rely heavily upon feldshers, i.e., semi-trained, semi-professional medical assistants; there exists, in effect, a "parallel network of medical facilities: one for the city population staffed by physicians, and one for the peasantry staffed mainly by feldshers."[8] Not infrequently, the feldshers are Party members who use their added authority in ways designed more to enhance their personal status than to ameliorate the medical shortcomings of the local peasantry.

In addition to the Ministry of Health of the 15 union-republics, control over all physicians and medical technicians is wielded through the Medical Workers' Union (*Medsantrud*). Membership is, in reality, compulsory: "failure to become a member would expose the physician to suspicion because the authorities expect the physician to join; and the fact that a nonmember suffers all kinds of economic and other disabilities. . . . In short, the *Medsantrud's* main task is to enlist the support of the physician behind the policies of the regime and to control him in all phases of his professional activities."[9] The physician is therefore subject to a variety of bureaucratic, political, and ideological controls which circumscribe his area of independent activity, place an effective ceiling on his earnings (though some specialists are permitted to have some private patients, physicians generally receive a straight salary which is fixed by the Government), and limit the opportunity for medical research.

MEDICAL RESEARCH

Since all research is financed and operated by the Government, the priorities established by the political leaders affect the character, direction, and tempo of medical research. Red-tape, inadequate funds, and stultifying

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[6] Mark G. Field, "A Spoonful of Soviet Medicine," *Problems of Communism,* Vol. XI (July–August 1962), p. 48.

[7] As quoted in Nicholas DeWitt, *Education and Professional Employment in the U.S.S.R.* (Washington, D.C.: National Science Foundation, 1961, pp. 294–5).

[8] Mark G. Field, *Doctor and Patient in Soviet Russia* (Cambridge: Harvard University Press, 1957, p. 100). Dr. Field's study is the most informative, balanced, full-length account of this aspect of Soviet society.

[9] *Ibid.,* pp. 55, 56.

bureaucratism act as commonplace deterrents to scientific inquiry. The Academy of Medical Sciences of the U.S.S.R. Ministry of Health is responsible for coordinating and supervising medical research in the whole of the U.S.S.R. It must approve of research projects and allocate the necessary funds also.

CENTRALIZATION

Centralization of planned research leads to considerable rigidity. Despite some impressive achievements in experimental surgical techniques, medical research in the Soviet Union is generally regarded as lagging far behind that in the West. In the U.S.S.R. most research is conducted by medical institutes; there is little done at the universities or hospitals. Medical schools are not closely linked to universities, thus minimizing the possibility of cross-fertilization of ideas from this source.

The Government has also chosen to put the overwhelming bulk of funds allocated for research into efforts to promote its industrial and military strength, i.e., electronics, metallurgy, missiles, and so forth. The result, according to one visiting American delegation, is that medical research "is lagging far behind research in other fields, that standards of training and the facilities for training—the priority given them—are second class as compared with our sciences and engineering. . . . Medical research institutes in general are crowded, archaic and obviously underprivileged in a setting where privilege is everything." However, it should be reiterated that so low was the general level of medical care in the U.S.S.R. that, until recently, the main emphasis of the Government was upon developing minimum facilities in all parts of the country.

OTHER SHORTCOMINGS

Other shortcomings may be mentioned: the pervasive bureaucracy with its premium upon conformity, avoidance of responsibility, and inertia; the sources of tension between the doctor and patient which arise out of the physicians' responsibility to sift out those with legitimate medical ailments from those who are malingering, while at the same time serving as the agent of the State to ensure that production goals are safeguarded. Dental care is seriously deficient; many medical centers are inadequately staffed. Clinics are invariably crowded, making individual needs difficult to keep in view. The pace of new medical construction has lagged.

ADVANTAGES

On the other hand, the system of medical care operated, financed, and controlled by the Government has not, judging by the reports of foreign observers, led to a depersonalization of the relationship between doctors and patients. The ready access to medical care, the absence of financial worry for the ill, and the expectation of adequate care as a right, are all undeniably attractive features of the system for Soviet citizens. Possibly because most of the physicians and medical personnel are women, visitors comment favorably upon the atmosphere encountered in hospitals and clinics.

According to Dr. Field, "the Soviet Union over the last four decades has developed a system of medical care dispensed as a public service, the extent of which (in terms of services and people) goes beyond anything attempted in this field. This system has the advantage of being centrally directed, and its development is theoretically geared to the general development of the society."[10]

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[10] *Ibid.*, pp. 223–224.

In West Germany, "the health insurance program has remained an integral part of the German social security system."

Health Insurance in West Germany

By Arnold Price
Area Specialist for Central Europe, Library of Congress

Germany was the first country to adopt a national health plan and the development of this program, which can be traced for almost 80 years through periods of economic expansion, war, revolution and social upheaval, is in itself a unique case history. Perhaps more important is the fact that West Germany's health insurance plan now covers over 80 per cent of the population of this highly industrialized country and that there as here the problem of national health insurance is a matter of current legislative effort and therefore under debate. Finally, West Germany's federal structure of government offers a special point of comparison. West Germany has a genuine division of power between its federal government and state governments, a division that varies substantially from American constitutional practice: while the West German federal government has exclusive jurisdiction in certain matters, such as defense and foreign affairs, it shares the right to legislate with the states in other fields. These fields of concurrent power include public health and social security. Moreover, the execution of federal legislation is left, as a rule, to the states.

The origins of the German health insurance program date back to the early years of the Bismarckian Empire, when Germany (after its defeat of France in 1871) was transforming itself rapidly from a paternalistic agricultural society into a modern industrial power.[1] The social and intellectual cross-currents of these years left their imprint on the social reforms instituted by the government.

Germany has a tradition of medical insurance dating back to the Middle Ages, with guilds and other associations of craftsmen providing medical aid to their members on a mutual basis. The abolition of the privileged position of the guilds in Germany during the nineteenth century was followed in many German states by special legislation continuing and extending such mutual benefit organizations on the local level. This type of insurance was most advanced in the field of mining where special hazards existed and where industrial working conditions had prevailed for some time. In 1854, Prussia made medical insurance for miners through their unions compulsory by legislation that provided for minimum benefits and a certain degree of self-government. By 1870, the other German states had followed suit.

The medical care policies of the various German states before 1870 were largely derived from the welfare concepts of the early modern period. In general, medical care for the indigent was covered by various laws assigning responsibility for caring for the poor to local authorities. In addition, certain groups of employers were made responsible for the medical care of their employees. And finally, as shown above, some of the burden

[1] For a detailed and brief history of German social security see: Horst Peters, *Die Geschichte der Sozialversicherung*, Bad Godesberg, 1959 (Fortbildung und Praxis, no. 39).

of the care was shifted to the employees themselves, by promoting mutual benefit organizations.

The foundation of the empire in 1871 made it possible to develop general health policies for the whole country. In 1871, the liability of industrial employers was enlarged by making them liable for accidents caused through the negligence of their agents. In 1876, the Reich government tried to regulate the various mutual associations and funds providing health benefits, and a law was enacted setting up uniform standards for their establishment and organization.

However, both acts proved to be unsatisfactory. The liability law placed the burden of proof on the employees, making the adjusting of claims cumbersome. On the other hand, the health insurance act left the initiative of organizing and extending such mutual funds to the local authorities and the net result was that the number of insured dropped from about 870,000 members in 1876 to about 715,000 members in 1880. It was at this juncture that Bismarck decided to initiate a thorough reform of this field of legislation,[2] and the system that resulted can be understood best in terms of his personality and policies.

BISMARCK'S LEGISLATION

Bismarck's main considerations were political. He wanted to show the working man that the state cared for him, in order to wean him away from Marxist ideas; in particular, this social security program was designed to offset the adverse impression the banning of the Socialist party had made on labor. In regard to the particular form of this program, Bismarck was essentially a pragmatist who derived his basic economic and social attitudes from his earlier life as a country squire. He had a deepseated distrust of the lower bureaucracy and also of big business, in particular of private insurance companies; but he had also some appreciation for the economic problems of the lower classes, an attitude that was curiously intermingled with concepts of a paternalistic social order.

Bismarck received little support for his program. The dominant school of liberal economists opposed this type of "state socialism" (as they called it); the churches were generally not yet ready to endorse such an extension of state power into a field that touched so closely upon their own charitable work; and labor was in no mood to back the man who had been responsible for the severe anti-Socialist legislation. Bismarck relied, however, on the ideas of a younger group of economists who had organized in 1872 the *Verein für Socialpolitik* (Social Policy Association) and who emphasized the need of social criteria for developing economic policies. The details of the program were worked out by senior civil servants who were often overruled by the chancellor, but who also modified his paternalistic concepts.

The basic policies of the program were outlined by William I in his famous speech from the throne (the so-called *Kaiserliche Botschaft*) of November 17, 1881. It proposed to protect the workingman against loss of income caused by illness, accident, or old age. The government introduced in parliament three separate bills, each covering one of these aspects.

The medical insurance act of 1883 was first to be passed. It introduced compulsory health insurance for all workers in industry, crafts, railroads, and inland navigation, as well as for white-collar employees in the same enterprises, but only for those earning less than 2,000 marks a year. The law provided for minimum benefits of free medical care and medication, up to 13 weeks of sick leave at half pay, maternity leave of three weeks at half pay, and a death allowance amounting to the pay of 20 days. The insurance was to be administered by health funds (*Krankenkassen*) that were modelled after the existing mutual funds and that were chartered by local government authorities.

Health funds were to be organized either by trade or enterprise. If no local health fund was available to a group of workers, the town or other local authority had to

[2] For a history of Bismarck's social security legislation see: Walter Vogel, *Bismarcks Arbeiterversicherung*. Braunschweig, 1951.

provide insurance. The health funds were made financially independent and had to rely for their income on contributions levied in terms of the wage or salary of those covered. Two per cent was considered a normal maximum rate. The worker paid two-thirds of the contribution and the employer one-third. The employer was made responsible for the collection of the contribution, and both labor and management were to be represented on the boards of the health funds.

The law permitted the inclusion of other categories of workers, the extension of benefits to dependents, and the increase of benefits by local ordinance. It also allowed the enrollment in other recognized insurance funds, the so-called auxiliary funds. It left the regulation of the health insurance for miners virtually to existing state legislation.

The accident insurance law of 1884 provided for medical care and sick pay or a pension after 13 weeks of treatment by a health fund for victims of industrial accidents. The insurance was carried by national or other trade organizations and was paid for by the employer according to the size of the enterprise and the risk involved. The law set up local arbitration boards and established the Reich Insurance Board (*Reichsversicherungsanstalt*) in Berlin as a national supervisory agency and as a final instance of appeal. The German accident insurance program expanded and developed parallel to the health insurance system. It now covers also accidents occurring on the way from and to work, as well as occupational diseases. The law for disability and old age pensions, passed in 1889, completed Bismarck's social security program.

Bismarck's health insurance law owed much of its success to the careful adaptation of early modern welfare concepts to the needs of a modern industrial society, to its reliance on experienced local organizations, and to its expansion potential. Yet, as the system expanded, it retained its basic framework, which had not been designed as a nationwide medical program, but as an answer to a specific welfare problem, i.e., of how to protect the poor workingman against the loss of income. Thus, in the beginning only 4,300,000 persons were covered and almost half of the expenditures was in the form of sick leave pay. The social components of the program were rather pronounced, such as setting the rate of contribution in terms of a wage percentage.

Moreover, little if any thought seems to have been given to the role of the medical profession. The health funds were empowered to appoint such licensed practitioners as they wished as panel doctors. However, the physicians organized and before World War I worked out a procedure by which appointments of panel doctors are handled by a joint committee of doctors and health fund representatives. Panel doctors are appointed for life and are considered self-employed. Most health funds permit their members free choice of any panel doctor for every treatment and require the doctor to submit his charges (which are fixed according to a fee schedule) to his local medical organization.

The health fund pays the medical organization a lump sum whose amount is calculated according to the number of persons covered by the insurance. The medical organization prorates this amount among the participating doctors in accordance with the amount of the charges submitted. During times of rising demands for medical care and during epidemics, the lump sum has been normally lower than the charges, resulting in a reduction of the claims that have been put forth by the individual doctors. Doctors are also held liable, if they exceed established maximum cost rates in prescribing medication or treatment. The health funds for miners require each member to register with a panel physician who is paid a lump sum according to the number of members registered with him.

COMPULSORY INSURANCE

By 1914, legislation had been passed to make health insurance compulsory for large additional groups of gainfully employed persons, to extend benefits, and to consolidate local health funds. Local government was

relieved of its obligation to provide health insurance. Membership in the health funds rose from 13 million in 1910 to 22 million in 1929. Special maternity legislation was passed in 1919 to include dependent mothers, and in 1929 obligatory medical care was extended to all dependents. However, the depression that began in that year brought about the first severe crisis of this program. With unemployment rising, membership dropped to 18.7 million in 1932 and expenses had to be curtailed from RM 2.2 billion in 1929 to RM 1.2 billion in 1932. This was largely accomplished through emergency decrees that reduced benefits and limited them in principle to the minimum level required by law. It also required a fee of RM .50 (about 12 cents) for each consultation and of RM .25 for each prescription filled.

The Nazi regime, following its totalitarian character, abolished local democratic control of the health funds and strengthened their semi-official status. In particular, it standardized their fiscal procedures and made them agents for a number of related government tasks. Thus, the health funds were charged with collecting from the employers the regular contributions for unemployment and old age insurance. As a result, the employer would now withhold both health insurance and other social security payments from the wages of his workers and employees. In 1941, the health funds were charged with providing medical care for receivers of old-age pensions in return for regular lump sum contributions from the pension funds.

The collapse of the Reich in 1945 deprived the health funds of most of their reserves which they had been obliged to invest in government bonds. Health insurance continued after the war, but it was not until the establishment of the Federal Republic in 1949 that general policies could be again developed and carried out, at least for that part of the country that remained free from Soviet control, i.e., West Germany.[3] Health insurance in West Germany covers now over 80 per cent of the population, i.e., 27.7 million members with about 19 million dependents in 1961 (see Table 1). Included are all blue-collar workers, all white-collar employees making less than DM 7,920 a year, receivers of public old age pensions, receivers of unemployment compensation, and certain categories of self-employed persons, mostly professionals.

Voluntary membership is open to entrepreneurs making less than DM 7,920 a year and to certain other categories of persons, mostly those whose insurance coverage is terminated because of a change in their status. However, public officials, physicians, students, members of religious orders (to name some) are excluded. In addition, the health funds have been agents for certain federal programs for which they get reimbursement by the West German government. They provide on this basis medical care to the large category of war victims, expellees and refugees.[4]

Benefits have been extended also. Free medical and dental care for illness is provided for, maternity benefits have been expanded, necessary medical supplies are issued free of charge, except that a fee of DM .50 must be paid for every prescription. Sick leave pay by the health fund has been increased to 65 per cent–75 per cent of the regular pay, depending on the family status of the patient, and is not to exceed 78 weeks during a three-year period. However, white-collar employees receive full sick pay from their employer for the first six weeks, while blue-collar workers are allowed a differential up to 90 per cent of their wages by their employer for the same period. Death benefits have been continued. Voluntary extension of benefits is generally permitted.

With increasing membership, rising wage

[3] In East Germany, all social security programs were unified and centralized and in 1956 they were placed under the control of the Communist Free German Trade Union Organization. In West Berlin, social security services were centralized in 1945 on a local level, but since 1949 their organization and procedures have been increasingly assimilated to those of the Federal Rpublic.

[4] For an up-to-date survey of West Germany's social security services see: Dieter Schewe and Karlhugo Nordhorn, *Übersicht über die soziale Sicherung in der Bundesrepublik Deutschland*. 4th ed. Bonn, Bundesministerium für Arbeit und Sozialordnung, 1962.

levels, and increased benefits, the expenditures of the health funds increased about 350 per cent between 1950 and 1959 (see Table 1). The proportionally largest increase occurred in cash benefits. This is largely due to a greater incidence of illness. Thus, annual sick pay benefits per member rose by 93 per cent (or from DM 27.73 to DM 53.56) between 1950 and 1956, while annual wage rates rose only 61 per cent during the same period. Similarly, the number of gainfully employed persons having a confining illness per 100 regular members of the health funds per year rose from 37.7 in 1935, to 55.4 in 1952, and to 68.8 in 1956.

By comparison, the increase in the cost of service benefits has been more regular. These increases were caused in part by the advances made in modern medical treatment and by their increased availability, as reconstruction after World War II progressed. In part, economic prosperity pushed costs upwards. The fee schedule was revised in 1952 for the first time since 1896, and again changed in 1957. As a result, the fee that can be claimed for an ordinary office visit has risen from about $.25 to about $.50. Contributions have also increased by necessity through increased membership coverage, rising wages, and declining unemployment However, the rate of the contributions has also risen: The average contribution actually paid has increased from 8.42 per cent of base pay in 1960 to 9.66 per cent of base pay in 1962. The employer must now pay one half the contribution. There is, however, a wide discrepancy in the actual amount collected by the various types of health funds per member. In 1953 it ranged from DM 110 for agricultural health funds to DM 259 for the mining health funds.

OLDER CITIZENS

German medical services have been very effective, but their high standards have increased the amount of medical care given. By extending life expectancy at birth from 35.5 years in 1870 to 68.3 years in 1949, they have enlarged the proportion of older people in the population, i.e., those particularly susceptible to illness. While before World War I, the number of persons age 65 and over constituted 5 per cent of the population, this figure was twice as large 40 years later. Roughly 20 per cent of the members of the health insurance are pensioners, i.e., persons too old or disabled to be gainfully employed, a group that the health funds have serviced at a loss.

The West German government has taken a keen interest in improving the health insurance program and introduced late in 1962 a package bill (the so-called *Sozialpaket*) for reforming various aspects of the German social security system. If passed, it would end the differentiation between workers and employees. Workers would be paid sick leave for the first six weeks by their employers and those earning above a certain amount would not have to be covered by health insurance. The bill tries to introduce various refund and cost-sharing provisions, designed to make those insured under the program think twice before asking for medical care. Also the fee system would be changed in a way that would provide for a more equitable payment for services rendered. Benefits would be increased by including preventive treatment, such as vaccinations, and by providing hospital care without a time limit.

While the aims of these proposals appear to be the logical continuations of a long-term trend, they do not touch upon the susceptibility of the health funds to economic fluctuations. Contributions are defined in wage percentages and will react to changes in the labor market. Moreover, the health funds have only limited amounts of reserves to back them up in time of crisis. The total assets of the health funds amounted in 1957 to some DM 600 million.

The organizational structure of the program has undergone few basic changes. All regular health funds are now consolidated on the local level. In 1961, there were 400 such consolidated funds, as well as 102 agricultural health funds, 1,330 health funds for large enterprises, 159 crafts health funds, 1 maritime health fund, 8 mining health funds, and 16 auxiliary health funds. Most health

funds are governed by an equal representation of employees and employers. There are about 42,000 physicians and 28,000 dentists who have been admitted to panel practice. Under a 1960 Constitutional Court ruling, no qualified practitioner may be denied admission.

The health insurance program has remained an integral part of the German social security system. The other components of this system have a similar coverage in membership and provide a certain amount of medical care, supplementing the benefits granted by the health funds. They are particularly concerned with chronic patients. These components, which include accident insurance, disability, old age, and survivors' insurance, and unemployment insurance are administered by public corporations or by state agencies. The states supervise the regional insurance corporations (including the health funds) that come under their jurisdiction. Those extending beyond one state are supervised by the Federal Insurance Board in Berlin. The top executive agency is the Federal Ministry for Labor and Social Affairs.

Supervision does not include the settlement of disputes. All suits arising out of social security legislation are settled by a special system of courts for social affairs, consisting of 48 local courts, 11 state appeal courts, and the Federal Supreme Court for Social Affairs (*Bundessozialgericht*) in Kassel.

In addition, the West German government supports or directly administers a number of medical programs for persons towards whom it has assumed a special responsibility of support. Thus it has a medical service for the armed forces and also, as noted above, provides through the health funds medical care for war victims and expellees.

Another field of activity of the West German government is that of public health.[5] Under the West German constitution, it has concurrent legislative powers in matters pertaining to infectious diseases, regulation of medical practice, and the control of the traffic with drugs. In this respect, it has continued a national legislative policy that dates back to the Bismarckian empire of 1871 and has maintained a comprehensive body of law covering all important aspects of public health.

However, the West German government has a rather small federal public health organization, consisting (1) of a Federal Ministry of Health, (2) of a Federal Health Office in Berlin, that is charged with the conduct of medical research through its subordinated institutes, the collection of health statistics, and the execution of a few statutory requirements, such as participation in international narcotics control, and (3) of the Federal Health Advisory Council.

The states are primarily responsible for the administration of public health and maintain central agencies for that purpose, as well as local health offices, which are charged with the enforcement of public health laws, with school, child, and maternal health, and with the care of certain illnesses that present special problems, such as addiction.

The West German government has also concurrent legislative power in the field of welfare and passed in 1961 a comprehensive social assistance act that emphasized rehabilitation. This social welfare program is administered by 566 local welfare authorities and 28 regional welfare districts, all of which are organized on the basis of state legislation. These organizations provide institutional care for disabled or chronically ill persons. The new program has continued many earlier policies, including the principle that all persons in need should obtain help, including medical aid.

[5] Cf. Friedrich Koch and Maria Daelen, *Das Gesundheitswesen in der Bundesrepublik Deutschland*. Stuttgart, 1954 (Schriftenreihe aus dem Gebiete des öffentlichen Gesundheitswesens, no. 1).

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"The French social security system plays a very important role in public health." This author points out that "the protection of the French workers against the hazards and uncertainty of contemporary economic life is apparently effective."

France: A Comprehensive Health Plan

By Henry C. Galant
Professor of Government, Skidmore College

Medical care in France today is largely provided by the social security system which was established by the Ordinances of October 4 and 19, 1945.[1] Thus, under social security, medical care is government sponsored, compulsory for most of the population, and provides benefits in kind and cash benefits to the insured person suffering an illness or incapacity. The French system retains the private practice of medicine and the free choice of doctor and hospital by the insured person. Some form of medical care coverage extends to all but 13.7 per cent of the population.[2]

Although there exist in France a number of specific and specialized systems, such as those for the mines and railways, where there are differences of administration and coverage, we are concerned here with the general social security system (*régime général*). This system is self-supporting out of contributions paid by the workers and employers and is not financed by general taxation. Since 1959 the employer has paid a 12.5 per cent contribution or tax and the employee 6 per cent. The payments made by the state for its own employees and civil servants and partial government subsidies to farmers, self-employed, students, and other special or hardship categories, provide the exception.

Private insurance, so important on the American scene, has not played an important role in covering the cost of medical care in France. A 1960–1961 study shows 8 per cent of the population covered by private insurance. Of the insured only 3.3 per cent are covered by private insurance alone.

The social security administration is decentralized, the autonomous, semi-public funds of which it consists comprising local, regional, and national funds (*caisses.*).[3] These funds (*caisses*) are administered by governing boards (*conseils d'administration*) made up largely of elected trade unionists and employers. Administration of the general system (*régime général*) is the responsibility of the Minister of Labor and Social Security. A civil servant, the Director General of Social Security is responsible for the detailed operation of the system.

The over-all French social security system is marked by a concern for demographic questions. The many and varied historic roots of social welfare legislation have resulted in a proliferation and dispersal of public

[1] Ordinance No. 45-2250, October 4, 1945, and Ordinance No. 45-2454, October 19, 1945. For details of the enactment and operation of the social security system, see my *L'Histoire Politique de la Sécurité Sociale,* Paris, Armand Colin, 1955.

[2] *Revue de la Sécurité Sociale,* No. 135, June 1962, pp. 32–34. (Publication Mensuelle, Fédération National des Organismes de Sécurité Sociale).

[3] 122 local funds (*caisses primaires*), 114 family allowances funds (*caisses d'allocations familialies*), 16 regional funds (*caisses régionales*), 1 national fund (*caisses nationale*). The May 12, 1960, decrees proposed revisions in the numbers and types of regional funds.

bodies concerning themselves with the overall health and welfare activities of the state: the ministries of Public Health and Population, Labor and Social Security, War Veterans and Victims, Reconstruction and Housing, National Education, Defense, and Agriculture.

The present French social security system, which emerged in the immediate post World War II years, 1945–1946, was, as indicated, marked first by its demographic concern with a declining population, low birth and high infant mortality rate,[4] and an aging population; and, secondly, by its preoccupation with inflation and concern with a redistribution of income. For a long time efforts had been made in France to secure some measure of social reform and legislation. These efforts prepared the way for the present comprehensive system.

The intervention of government authority in providing medical care has a long history in France. In the pre-revolutionary period the religious authority was largely responsible for teaching and for various forms of public assistance and charity. The hospitals and the poor were a parish concern in the very way that they are now a municipal concern.

The church was able to play this social welfare role because it had regular resources of its own. It was authorized to receive gifts and bequests. It enjoyed considerable tax exemption. It was able to carry on profit-making activities in agriculture and the crafts. It was also the channel or vehicle for royal charity.

State intervention in the building of hospitals and in the care and aid of the poor is thus to some extent only a modern phenomenon in that it has been secularized; it was a redistribution of activities between different public bodies rather than an extension of collective tasks.[5]

The initial revolutionary confiscation and redistribution of church property and resources, in failing to recognize the social welfare aspect of church activity, resulted in disorder and confusion in the area of public health.

In the middle ages many hospitals and hospices (asylums or almshouses) for pilgrims and the poor were established. These hospitals (the largest hospitals in the towns and cities were the Hôtel-Dieu) received the sick, the old, the orphaned or abandoned children, as well as pregnant women. Unlike our present conception, the word hospital then had a broader meaning. In essence, a hospital was a state-recognized charitable institution that catered to various categories of the needy, be they sick, disabled, or merely dependent.

Most of these hospitals were maintained by religious orders such as the Brothers of Charity, the members of St. John of God, and the Lazarists. Some hospitals were restricted to the treatment of one or more diseases, but the Hôtels-Dieu treated almost all types of diseases. Simple remedies were gratuitously administered.

Perhaps treatment is an exaggerated description, because little medical technique was employed. Three or four sick and ailing were commonly placed in one bed, with little attention paid to their particular affliction. The lying-in wards might be next to the smallpox ward and the surgical ward next to the mental ward. No wonder one reads of their becoming veritable pest houses. The most notorious was the Hôtel-Dieu of Paris where heavy mortality rates resulted from starvation and infection.

Doctors and the then surgeons were not attached to or in attendance in the hospitals until the early fourteenth century.[6] It should be noted that prior to the French revolution there already were pressures for and evidence of the separation of patients by category of disease and provision for single individual beds.

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[4] The birth rate rose from 14.6 per 1,000 inhabitants in 1939 to a postwar peak of 20.9 in 1949.

[5] Henri Pequignot, "Scientific and Social Aspects of Modern Medicine," *Impact of Science on Society Quarterly* (UNESCO), Vol. V, No. 4, December, 1954, pp. 217–218.

[6] *See* Jean Imbert, *Les Hôpitaux en France,* Presses Universitaires de France, Paris, 1958, pp. 13–19.

Shelby T. McCloy, *Government Assistance in 18th Century France,* Duke University Press, 1946, pp. 181–210.

George Rosen, *A History of Public Health,* MD Publications, 1958, pp. 81–130, 131–191.

Impoverishment due to the Hundred Years War, the religious wars, and just simple abuse or misuse of funds led to ever-increasing state intervention in the administration and control of hospitals and to the use of specifically earmarked taxes for public welfare programs. In the sixteenth century, many hospitals were administered by committees of leading citizens, lay and ecclesiastical, chosen for their prominence or influence in the community.

Under Cardinal Mazarin, in the seventeenth century, general hospitals (*hôpitaux généraux*) were established. These were a combination of hospitals and almshouses. A royal decree of 1612 ordered the establishment of a general hospital in every important city "to lodge, confine, and feed the poor beggars and sick, native to the area or having lived there for at least a year, as well as children orphaned or born to indigent parents."[7]

There was widespread criticism of the lamentable state of the hospitals in the prerevolutionary years, and in the early revolutionary years many voiced preference for some form of home care and a nationally conceived hospital plan and form of assistance.

Under the Convention the hospitals were nationalized and put under lay control, and the principle of free entry to the nearest hospital to anyone, regardless of domicile or place of origin, was established. Later, when the hospitals were placed under local control and under a local administrative commission (October 7, 1796), this generous principle was rarely observed. Paucity of financial resources and the great disparity of standards and unequal *départmental* distribution of hospitals made it impossible to implement. The only exception to this rule was applied to the military sick who were eagerly received because their hospital costs were remunerated by the military authorities.

The Napoleonic administrative reforms placed the hospitals under a greater degree of central government supervision, and by the twentieth century a more systematic and regular control developed. The "taint" of charity and the general backwardness and paucity of French hospitals, in spite of significant exceptions, led to an increase in the number of private and semi-public hospitals and clinical establishments, particularly those envisaged and already established by the welfare funds of the social security administration.

In 1950, there were 330,000 hospital beds in the public sector, of which 189,000 were for sickness and maternity cases and 143,000 for the old and infirm. In the private establishments, there were about 78,000 beds, of which 53,000 were for sickness and maternity cases. This situation has led to a running controversy about the need for and value of competition between public and private entities in the health sector. Comparisons of operating costs are difficult and to many invidious, for the public hospital must admit anyone and, in the final analysis, often gets the most difficult and hopeless cases.

Today the public hospitals are not mere hostels for the sick and poor but operate as a public service and are marked by the automatic financing of their current expenditures by public authorities and the social security system. By decree of October 19, 1951, they are open to all patients, regardless of resources, who pay their bills on their own via social security reimbursements or assistance payments. The growth of the social security system, which reimburses hospitalization costs, has accelerated the evolution of the French public hospital in the direction of a new center for public health research and teaching and has challenged the medical profession itself.[8]

In addition to vigorous activity in establishing and subsidizing a variety of clinics, rest and convalescent homes, health and welfare funds (*fonds d'action sanitaire et social*) of the social security system contribute to hospital construction and renovation. This contribution is equal to French state participation of 30–40 per cent in hospital construction and renovation.

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[7] My free translation of quotation on page 25 of Imbert, *op. cit.*, pp. 22–32.

[8] See Robert Debré, "La Réforme Médical," *La Revue de Paris,* November, 1961, pp. 14–24.

The social security system has further helped the hospitals by the reimbursements for socially insured patients. Whereas in 1947 social security reimbursements made up 54 per cent of the hospital costs, by 1951 they constituted 68 per cent and continue to increase. The hospital treatment expenses are calculated on the basis of actual cost price.

The whole question of what is included in over-all hospital cost, the role of hospitals, medical control, and the nature of staffing and type of service is an evolving and very open issue in France today.

Although there have been some fine achievements in hospital construction and modernization these last few years, the hospitals still remain a critical area. Even today there are hospitals in important towns that have wards of 20, 30, and even 40 beds.

CHILD HEALTH AND MATERNITY CARE

As a result of a long-term static population and even a diminishing one just before World War II, France has long been a pioneer in matters of child health and maternity care. State subsidies as well as direct intervention were extended early to municipal and private agencies.

The Foundlings Hospital of Paris was established in 1670. In 1797 the Convention passed farsighted (if not applied) laws relating to the welfare of infants of indigent families and abandoned infants.[9]

The growing industrialization of France in the nineteenth century brought with it the attendant miseries of a lack of proper housing, overcrowding, exploitation and child labor. In 1841, a law regulating child labor in factories was passed. This forbade employment of children under 8, while permitting children between 8 and 12 to work an 8-hour day, and those between 12 and 16 not more than 12 hours a day.

Toward the end of the nineteenth century France embarked on an important program of infant and child care. François-Joseph Herrgott and particularly Pierre Budin were instrumental in developing child welfare clinics and in combating infant mortality in France. Simultaneously, stress was placed on the establishment of milk stations (*gouttes de lait*) where mothers could obtain clean cow's milk at reasonable prices. Preoccupation with infant feeding and its regulation has a long history in France. As early as 1705 a law was concerned with regulation of wet nurses.[10]

In 1874 the Roussel Law put into effect the supervision of children under two put out to nurse[11] and of the institutions or homes in which they were placed, whether at private or public expense. A decree of 1897 called for the supervision of day *crèches* and other places handling children under three and instituted compulsory medical supervision.

The right of an employed woman to have a rest period of eight weeks before and after the birth of a child was provided for by a 1909 law. Although under this law the employer was not obliged to pay her during her absence, he did have to guarantee her place would be open upon her return.

A 1913 law further protected the woman employee during pregnancy by enabling her to leave work if her health called for it without the leave being considered a breach of contract. Some provision for confinement rest was made. In terms of a preoccupation with welfare and the need for improved health and sanitary standards, the mothers were given hygienic information along with their benefits and the visit of the then social worker (*dame visiteuse*).

The early twentieth century saw the establishment and maintenance of convalescent homes for mothers and canteens for expectant and nursing mothers. Provision was made for domestic assistance and the care of the older children during a confinement.

The paternalism which bred the first family allowances culminated in the very comprehensive government sponsored family allowances schemes under the 1945–1946 Ordi-

[9] See T. G. H. Drake, "Infant Welfare Laws in France in the 18th Century," *Annals of Medical History*, Vol. VII, No. 1, January, 1935, pp. 59–61.
[10] Drake, *op. cit.*, pp. 50–56.
[11] See Nettie McGill, *Infant Welfare Work in Europe*, Government Printing Office, Washington, 1921, especially pages 81–83.

nances, which is so important and distinctive a feature of French social security. Indeed the employer's tax or contribution to family allowances—14.25 per cent—is higher than that for social insurance—12.50 per cent—and indicates the high priority given to family needs.

SOCIAL SECURITY AND MEDICAL CARE

The general system of social security which came into effect under the Ordinances of October, 1945, embraced three major types of benefits: social insurance, family allowances, and insurance for industrial accidents and occupational diseases.

Social insurance covers the risk of sickness and long sickness, maternity, disability and old age.

Sickness insurance benefits involve the refund of medical expenses and the payment of an allowance to compensate for the loss of earnings during the period of sickness. The cost of hospitalization and drugs and the fees of doctors and dentists are reimbursed from 80 to 100 per cent of the cost or fee, depending on the type of treatment.

The allowance paid as compensation for a loss of earnings is equal to one-half the daily wage commencing on the fourth day following the cessation of work and for a maximum six-month period.

Long term sickness or extended illness (cancer, tuberculosis, and so forth) which necessitates a work stoppage of more than six months calls for a 100 per cent reimbursement of all medical expenses during the period of the illness. The cash allowance may continue for a period of three years.

Maternity insurance covers the cost of all medical and hospital expenses incurred as a result of a pregnancy. Provided the insured woman remains away from work for at least six weeks after the birth of a child, she is entitled to a daily allowance. This is computed in the same manner as the sickness insurance described above. This allowance is paid for a period of six weeks before the birth and eight weeks after the birth of the baby.

In addition to the social insurance maternity provisions, maternity benefits falling under the system of family allowances are paid to all women during and after a pregnancy. Prenatal allowances, amounting to 25 per cent of the standard wage of the region, are paid from conception to the birth of the child.

Another important component of family allowances is the monthly cash payment to each family with at least two dependent children up to age 15 and, if the child continues schooling, up to the age of 20. For a family with two children the monthly payments equal 22 per cent of the standard wage. For the third and each subsequent child the amount is 33 per cent of the standard wage.[12]

IMPACT ON THE MEDICAL PROFESSION

The continuing extension of social insurance to cover all wage earners and their families has resulted in drastically limiting the private clientèle of doctors; roughly 90 per cent of their patients are socially insured. Such a transformation inevitably changes the conditions under which medicine is practiced.

Today, a collective agreement has largely replaced the previous direct individual agreement between the doctor and his patient. Although the 1945 Ordinance called for collective agreements, the policy was never enforced until de Gaulle's reform of May 12, 1960, which spelled out the procedure and the penalities for non-observance. These collective agreements have narrowed the gap between the statutory tariff and the reimbursement limit. The insured person thus has to pay only the personal share of 20 per cent required by law (*ticket modérateur*).

For years, lacking an agreement, the doctors' charges were much higher than the reimbursement limits of the funds. The patients thus bore more than the law proposed. This situation not only caused friction between the social security system and the medical profession but resulted in widespread discontent among the insured. I believe this explains the little public support the doctors

[12] See Wallace C. Peterson, *The Welfare State in France*, University of Nebraska Press, 1960, pp. 25–28.

CHART I*

SICKNESS INSURANCE—"GENERAL SYSTEM"

(in millions of new francs—approx.)

	1949	1956	1961	Coefficient of rise in relation to 1949	Coefficient of rise in relation to 1956
Dental Costs	54	145	413	7.65	2.85
Drug Costs	141	650	1297	9.20	1.99
Hospitalization	281	920	2030	7.22	2.20
Medical Costs	122	314	788	6.46	2.51
Surgical Costs	46	179	402	8.74	2.25
Total (including other costs of sickness insurance)	878	2898	6238	7.10	2.15

* Culled and combined from charts, pages 43–44, *Revue de La Sécurité Sociale,* No. 139, November, 1962.

received in their resistance to the May 12, 1960, decree and in their ensuing strike.

In an official poll taken in 1959[13] about 87 per cent of the sample said they were reimbursed less than the 80 per cent provided by law. Only about a quarter of the sampling preferred the direct payment system. This would suggest an exaggerated emphasis by the doctor on the value and popularity of direct doctor-patient relationship.

French doctors were first confronted by compulsory social insurance legislation, even though limited, by the laws of 1928–1930.[14] At this time the French medical profession averted the imposition of "third payers" and "fee schedules" advocated by some legislators. It is interesting to note that the threat to the liberal practice of medicine implied in compulsory insurance in 1928 sufficed to draw together the French medical profession into a single large professional grouping, C.S.M.F. (*Confédération des Syndicats Médicaux Français*).

The May 12, 1960, Social Security Law required the fixing of scales of fees for doctors by collective agreement, or, failing that, a fee schedule decreed by the Ministry of Labor. This law split the C.S.M.F. and resulted in the expulsion[15] of certain local medical groups, the formation of a new professional medical organization, U.S.R. (later U.N.S.M.),[16] which opted to stay outside the system and refused to sign collective agreements.

The scales of medical fees for medical care of all kinds, including maternity care, are fixed for each *département* by agreements (*conventions médicales*) between the regional social security funds and the most representative medical associations, i.e., between the organizations of the insured persons and the doctors' organization. These scales of fees and agreements come into force after approval by an Interministerial Committee on Tariffs.

In those areas where a collective agreement is not reached, the 1960 reform act permits an individual doctor to agree to observe specific provisions such as a scale of fees. By signing an individual agreement the doctor is covered by the provisions and benefits provided by the collective agreement. This is one of the provisions most hotly contested by the organized medical profession.

In those *départements* where agreement cannot be reached or where an agreement

[13] Jean-Daniel Reynaud and Antoinette Catrice-Lorey, *Les Assurés et La Sécurité Sociale,* University of Paris, Institut des Sciences Sociales du Travail, 1959. Tome I, pp. 17–18, p. 26.

[14] These laws compulsorily covered wage earners under a certain income. *See* Barbara N. Armstrong, *The Health Insurance Doctor,* Princeton University Press, 1939, pp. 165–258.

[15] See *Le Concours Médical* No. 47, Nov. 25, 1961, pp. 6131–6133.

[16] L'U.S.R. (Union Syndicale pour la Réforme du Décret du 12 mai 1960) L'U.N.S.M. (L'Union Nationale des Syndicats Médicaux de France).

CHART II**

RELATIVE IMPORTANCE OF EACH CATEGORY OF EXPENDITURE TO THE TOTAL ANNUAL SICKNESS EXPENDITURES.

	1949	1956	1961
Dental Costs	6.2	5.0	6.6
Drug Costs	16.1	22.4	20.8
Hospitalization	32.0	31.7	32.5
Medical Costs	13.8	10.8	12.6
Surgical Costs	5.2	6.3	6.5

** *Ibid., Revue de La Sécurité Sociale,* p. 47.

is revoked, the regional social security director summons the parties to come to some agreement. If within two months no agreement is reached, the Interministerial Committee on Tariffs fixes the fee scale applicable to these doctors and to those who adhere individually to the compulsory clauses of the model agreement.

As of December, 1962, there were ten *départements* which include such important ones as the Rhône (Lyon), Alpes-Maritime (Nice) and Seine (Paris) who failed to sign a collective agreement and are thus subjected to an imposed fee scale. The 4,660 doctors who have adhered individually, added to the 544 radiologists under separate agreement, constitute approximately 44 per cent of the doctors practicing in these ten *départements.* The importance of the social security clientèle forces many doctors, particularly in poor populous sections, to sign an individual agreement.

In 1947, shortly after the Social Security System was put into effect, there were 24 medical agreements affecting about 27 per cent of the insured. In November, 1962, (a little over two years after the May 12, 1960 decree) there were 89 medical agreements (plus four agreements in overseas *départements*) covering 69 per cent of the insured.[17]

Dentists have signed agreements in all but two of the départements, the important ones of the Seine, and Seine and Oise (Paris area) but adding the individual agreements to this total, we find almost 92 per cent of the dentists adhering.

The decrees of May 12, 1960, which put the above measures into effect, have been greeted with a form of cold war resistance by a large segment of the medical profession[18] largely centered in Paris and Lyon. To these doctors this government intervention and regulation of medical care is a challenge to their traditional doctor-patient relationship which stresses the fee for service principle, the direct doctor-patient relationship, and privileged communication.

Medical expenditure has shown a continuing rise these past years. Medical consumption has proceeded regularly with an 8 per cent annual increase in volume from 1950 to 1958. The most rapid rise in expenditure is in pharmaceuticals which has increased by more than 300 per cent (in current prices) in the eight-year period. Medical expenditure in the aggregate has increased by 255 per cent. The percentage of over-all consumption represented by medical consumption rose from 4.7 in 1950 to 7.3 in 1958.[19]

It is interesting to note the marked increase in expenditures in the 1960–1962 period which in addition to being part of a continuing pattern of growth in medical consumption is influenced by the higher reimbursements made possible by the broad extension of collective and individual agreements affecting, as noted previously, 69 per cent of the insured. If we compare the first

[17] Information from the 8th Bureau of the Ministry of Labor in Paris.

[18] See, for example, a bitter criticism by Jean Robert Débray in *Financing Medical Care,* Caldwell Printers, 1962, pp. 99–136.

[19] *International Social Security Association Bulletin,* Vol. 13, No. 6, June, 1960, pp. 290–293.

CHART III***

DISTRIBUTION OF THE PRINCIPAL CATEGORIES OF SOCIAL INSURANCE EXPENDITURES

	1949	1956	1961
Disability	3.4%	3.7%	3.3%
Maternity	4.7%	3.4%	3.5%
Old Age	35.6%	30.9%	26.8%
Sickness	43.2%	53.4%	57.6%

*** *Ibid., Revue de La Sécurité Sociale,* p. 29.
The most significant feature of these figures is the percentage rise of sickness expenditures in the total. A high birth rate and lower death rate, of course, contribute to this increase.

six months of 1960 which precede the May 12 decree with the first 6 months of 1961 and 1962 respectively, there is a 63 per cent increase in over-all expenditures of 1961 over 1960 and an 86 per cent increase of over-all expenditures of 1962 over 1960.[20]

Medical costs alone rose 47 per cent in the 1960–1961 period, while dental costs soared to a 122 per cent rise. In the 1960–1962 comparison, medical costs rose 72 per cent while dental costs continued their rapid rise to 147 per cent.

With 92 per cent of the dentists falling under the provisions of collective and individual agreements, the increased reimbursement to the insured no doubt stimulated consumption and also represents the additional cost of reimbursement to the social security system.

Charts I, II, and III further indicate the rise and relative costs of the various categories of sickness insurance. (See pages 356, 357, 358.)

The French social security system plays a very important role in public health. In 1955, health expenditures accounted for 5.05 per cent of the French national income, and the share of social security in the health budget was 50.7 per cent.[21] This is too low a proportion of state, local, and private funds if pressing health needs are to be met.

The protection of the French workers against the hazards and uncertainty of contemporary economic life is apparently effective. In a ten-year period between 1949 and 1960 the social insurance and assistance component of household income rose from 15.9 per cent in 1949 to 20.7 per cent in 1960. While total income available to households tripled, that of the social component quadrupled.[22]

The following examples culled from the data gathered in the previously mentioned poll would indicate rather widespread support for and acceptance of the social security system. In the sampling, 95.1 per cent of the French workers approved of compulsory social security coverage and 86.4 per cent approved of the insurance principle that it was appropriate for the healthy to pay for the sick.[23]

It is difficult to gauge the impact of social security on the demographic situation, but it no doubt has played a role. Preliminary data of the 1962 census show a continuing natural annual population increase of roughly 7 per cent. This is heartening when one com-

(*Continued on page 368*)

[20] Statistics from the 8th Bureau, Ministry of Labor, Paris.
[21] Norbert Legrand, *Industrie Pharmaceutique et Problèmes de la Santé.* Brussels, Editions Arcsia, 1959, pp. 253–254.
[22] See *Rapport sur les Comptes de la Nation de l'Année,* 1960, Paris, Imprimerie Nationale, 1961, especially page 65.
[23] Reynaud and Catrice-Lorey, *op. cit.,* pp. 158–159.

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In India, "Health programs, like all other development programs of the country, are planned on a phased basis, fitting into the country's five-year plans." This specialist points out that "It is recognized that health is fundamental to national progress in any sphere and that it is a vital part of a concurrent and integrated program of development of all aspects of community life."

Public Medicine in India

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India, with a population of 438 million, is a country of many diversities. If instead of thinking of it as a single nation we consider it as an aggregate of nations, each similar in its basic concepts and philosophy of life yet different in many important respects, we may be able to comprehend the complexity of India's health problems. Diversities in the physiography of the country and in climatic variations are reflected not only in the physical features, manner of living, and diet of the people, but also in the health problems with which they are faced.

In October, 1943, the Government of India appointed the Health Survey and Development Committee (Bhore Committee with Sir Joseph Bhore as the chairman) to make a broad survey of health conditions and health organization in British India, with recommendations for future development.[1] This Committee in its 1946 report pointed out that the maintenance of public health requires the fulfillment of certain fundamental conditions: an environment conducive to healthful living; adequate nutrition; health protection (preventive and curative) available to all members of the community irrespective of their ability to pay for it; and the active cooperation of the people in the maintenance of their own health. These concepts have been the basis of health planning in India since its independence.

The dual event of the attainment of independence in 1947 and the submission of the Bhore Committee report in 1946 led to certain important changes in the health administration. One of the recommendations made by the Bhore Committee was that both at the national and state levels medical and public health departments should be combined under a single administrative head. At the national level the two posts of Director General of the Indian Medical Service and Public Health Commissioner were abolished in August 15, 1947; they were replaced by the post of Director General of Health Services, who is now the principal adviser to the Government in both medical and public health matters. A similar change has taken place in most of the states to bring about the administrative coordination of creative and preventive health services.

The constitutional changes following the new status of the country provided an occasion for reviewing the division of function in the field of health between the national and state governments. The national government, responsible both in the legislative and executive fields, gives advice on health and allied

[1] *Report of Health Survey and Development Committee,* Vol. 1, New Delhi, Government of India Press, 1946, pp. 1–11.

matters, coordinates health programs and policies, implements state programs with grants-in-aid, supplies technical information and equipment, and provides financial and other assistance towards health measures which promote the health and well-being of the country in general. Thus it mainly guides, assists and coordinates.

DIVISION OF RESPONSIBILITY

The national government also plays a leading role in postgraduate training, medical education, medical research, the development of medical care services and national health programs for diseases such as malaria, tuberculosis and smallpox. It formulates national policy on health matters with the assistance of expert committees.

The states are responsible for their own medical, nursing, and allied education for public health and sanitation, for provision and operation of hospitals and dispensaries, and for a wide variety of other functions. The expansion of health services at the state level is implemented through grants for the construction and equipment of hospitals and primary health centers, and through health insurance programs under the Employees State Insurance Act.[2]

State health ministries and corporation and village panchayats[3] implement the relevant programs and policies. One of the directive principles of the Constitution of India is that the state shall take steps to organize village panchayats and endow them with such powers and authority as may be necessary to work as units of self-government (Article 90). The members are elected by and from the villages and are responsible for agricultural production; rural industries; medical relief; maternal and child welfare; maintenance of village roads, streets, tanks, wells; and provision of sanitation and drainage.

Thus we see that the ministry of health, national or state, not only is the ultimate authority responsible for all the health services operating within its jurisdiction but also has power to lay down and enforce minimum standards of health administration for those services which are within the immediate control of other departments, such as railways, prisons, industry, and so on.[4]

HEALTH AND PLANNING

Health programs, like all other development programs of the country, are planned on a phased basis, fitting into the country's five-year plans. The pattern of priorities to be followed during a particular plan period takes into account the immediate needs of the economy as well as the desirability of initiating certain long-term changes in the economic structure which will raise the standard of living of the people and furnish opportunities for a richer and more varied life.

In the first five-year plan top priority was given to agriculture, including irrigation and power.[5] The principal objective of the second five-year plan was to achieve a more rapid growth of the national economy and to increase the country's productive potential in a way that would make possible accelerated development in the succeeding plans. The building up of economic and social capital, the development of minerals, and the promotion of basic industries like steel, machine building, coal, and heavy chemicals were considered vital. The planners believe that development should result in diminution of economic and social inequality and should be achieved through democratic means and processes.[6] India entered the third five-year plan in 1961 with the main objectives not only of rapidly expanding the country's economy but also of making it self-reliant and self-generating. With the purpose of providing economic

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[2] In each Community Development Block (circa 100 villages with approximately 66,000 population) a primary health center has been established to provide health care for the people. It provides both curative and preventive services with emphasis on preventive aspects.

[3] Village panchayat: A system of democratic decentralization which involves a three-tier structure of local self-governing bodies at the village, block, and district level has recently been introduced; the unit at the village level is a village panchayat.

[4] Shri B. R. Tandon, *Health Administration in India*, Swasth Hind, New Delhi, February 1961, p. 109.

[5] *The First Five-Year Plan, A Summary*, Government of India Planning Commission, 1951.

[6] *Second Five-Year Plan, A Draft Outline*, Government of India Planning Commission, 1956.

TABLE 1. DISTRIBUTION OF OUTLAY[8]

Program	RS (Crores)* First Plan	Second Plan	Third Plan
Health			
Water Supply and Sanitation (rural & urban)	49.0	76.0	105.3
Primary Health Units, hospitals & dispensaries	25.0	36.0	61.7
Control of communicable diseases	23.1	64.0	70.5
Education, training and research	21.6	36.0	56.3
Indigenous systems of medicine, homeopathy and nature cure	0.4	4.0	9.8
Other schemes	20.2	6.0	11.2
Family Planning	0.7	3.0	27.0
Total	140.0	225.0	341.8

The per capita expenditure on medical and public health services in 1956–1957 varied from a low of 14 cents in Kerala to a high of 47 cents in West Bengal.
* There are approximately five rupees to a dollar. One crore is equal to 10,000,000 rupees.

stability, top priority is being given once again to organized industry and minerals, transport and communications, agriculture, irrigation and power.[7]

It is recognized that health is fundamental to national progress in any sphere and that it is a vital part of a concurrent and integrated program of development of all aspects of community life. The Government took cognizance of the fact that lack of a hygienic environment (housing, water supply, and removal of wastes), low resistance resulting from poor nutrition, insufficient medical care resources, lack of general and health education, and a low economic status were the main causes of the prevailing low state of health. These problems were further exaggerated by lack of trained medical and health personnel and by fantastic population growth. Thus we see that priorities in health planning are placed on basic environmental sanitation, control of communicable diseases, health services for mothers and children, health education, and the important and increasing problem of family planning and population control.

Though the percentage allocated for health programs from the total outlay has shown a slight decline over the period of the three plans, the increasing actual outlays of $300 million and $480 million in the first and second plans respectively, and $720 million in the third five-year plan point out the importance health is acquiring in national planning. The main distribution of the health outlay given in the table above depicts areas receiving increasing priority.

THE PRIMARY HEALTH CENTER

> While our cities and towns require to be looked after much better than they are at present, it is really the village that has been terribly neglected and cries aloud for succour. Public health must, therefore, go to the village, and the village should not be compelled to come to the town in search of it. (Pandit Nehru.)

Nearly 80 per cent of India's millions live in its villages. For any health program to be effective it must reach out to the majority. Medical practitioners in India as elsewhere tend to cluster in urban areas; this leaves the rural areas unmanned by physicians so that it becomes incumbent upon the government to provide its people with medical aid both curative and preventive.

Though certain charitable institutions participate in giving relief, medical care remains primarily the responsibility of the states. This is being provided through primary health centers which are being established in each community development block. Nearly 3,000 such rural health centers have been established over the past decade, each serving a

[7] *Third Five-Year Plan*, Government of India Planning Commission, 1961.
[8] *Health and Family Planning*, Third Five-Year Plan, Government of India Planning Commission, 1961, p. 651.

block area with an average population of 66,000 (spread throughout 100 villages). These centers are the focus of both preventive health services and curative services through the out-patient departments and hospital and mobile field units. Environmental sanitation, maternal and child welfare, family planning, health education, control of communicable diseases and collection of vital statistics are some of the basic preventive services provided.

Besides strengthening these centers attempts are also being made to integrate some special services, such as eradication of malaria and smallpox and control of tuberculosis, with the normal activities of the unit.

To ensure that special services are readily made available to them, these primary health centers are linked with district and city hospitals for referral and consultation. However, the major problem is to secure physicians to take up posts in the primary health centers. Some suggestions have been made to overcome this difficulty and to create a climate more congenial to the physicians. It has been recommended that the states have a single cadre of personnel working in urban and rural areas, that a certain period of rural service be mandatory for all staff, and that this be taken into account for advanced increments, accelerated promotions, and postgraduate training. Provision of proper residential accommodations and other facilities for the rural staff is also recommended. Scholarships should be made available to students undergoing training with the obligation that they serve in rural areas after graduation for a minimum prescribed period.[9]

Though the hospitals are mainly concentrated in the urban areas, in the rural areas the primary health centers (each with an indoor arrangement of six beds) try to cater to the rural requirements. Though meager, this is a beginning—referral sources are established within the district and subdivisional hospitals and ambulance services are available at the primary health center. The number of hospitals and dispensaries has increased from 8,600 in 1951 to 12,600 in 1961 and during the same period the beds have increased from 113,000 to 185,600. The over-all target of the third plan is the establishment of 2,000 more hospitals and dispensaries and 54,500 additional beds.

Though the nucleus of social security in rural areas is now the joint family system, in the industralized communities the Workmen's Compensation Act of 1923 and the State Maternity Acts may be considered as additional nuclei of social security. The great step forward in this field was the passage of the Employees State Insurance Act in 1948 and the introduction of the Contributory Health Service scheme for national government servants in Delhi and New Delhi in 1954. These are based on the cooperative efforts of employee and employer.

The Employees State Insurance Scheme. This provides medical benefits to nearly 50 per cent of the industrial workers. Under this scheme, an insured worker and his family are entitled to receive medical help in the State Insurance dispensaries or in panel doctors' clinics, at their residences, and in hospitals.

Colliery and mica workers receive medical help in institutions maintained respectively by the Coal Mines Labor Welfare Fund and the Mica Mines Labor Welfare Fund. Today, private employers as well as state governments provide medical services for their employees.[10]

Contributory Health Service Scheme. This started on July 1, 1954, and is at present confined to Delhi and New Delhi. It serves 456,000 national government employees and their families (inclusive of dependent parents). The employees' contributions are based on a graduated scale varying from about 10 cents to $2.50 per month according to their emoluments. This is only a token contribution and is no indication of the total expenditure for this program, the major share of which is borne by the Government. The staff of certain autonomous and semi-governmental organizations and their families have been admitted to the scheme. The scheme provides free medical attendance for govern-

[9] *Primary Health Units, Hospitals and Dispensaries,* Third Five-Year Plan, Planning Commission, Government of India, 1961, p. 657.

[10] *Health Insurance,* India, 1962, Publications Division, Ministry of Information and Broadcasting, p. 110.

TABLE 2. ACHIEVEMENTS AND TARGETS**

Medical education	1950–51	1955–56	1960–61	1965–66
Medical colleges	30	42	57	75
Annual admissions	2,500	3,500	5,800	8,000
Dental education				
Dental colleges	4	7	10	14
Annual admissions	150	231	281	400
Training programmes				
Doctors†	56,000	65,000	70,000	81,000
Nurses†	15,000	18,500	27,000	45,000
Auxiliary nurse-midwives & midwives	8,000	12,780	19,900	48,500
Health visitors†	521	800	1,500	3,500
*Nurse-dais/dais†	1,800	6,400	11,500	40,000
Sanitary inspectors†	3,500	4,000	6,000	19,200

† Number indicates the number in practice or in service.
* The units will be withdrawn gradually in the latter part of the Third Plan. Dai—acts as midwife especially suited for rural environments. She has only six months to one year of training.

** The material in this chart is taken from *Health Progress and Programmes,* Third Five-Year Plan, Planning Commission, Government of India, 1962, p. 653.

ment servants and their families at the dispensaries and at their residences, all necessary drugs, laboratory and x-ray investigations, ambulance services, in-patient services for all medical and surgical cases including operations, antenatal care, confinement and postnatal care for women, emergency treatment, specialist care, supply of optical and dental aids at reasonable scheduled rates by government-approved opticians and dentists, and advice on family planning, including supplies of free and subsidized contraceptive appliances.[11]

In the light of experience gained, other schemes of this nature will be worked out by the national and state governments so that over a period of time a large section of the population will be covered by a comprehensive system of contributory health insurance.

EDUCATION AND TRAINING

Medical education in general is the responsibility of the states, the Government's main interest being promotion of higher studies and specific programs of research and specialized training. There are at present 65 medical colleges. The end of the third plan period will see a total of 75 medical colleges in the country. However, the expansion of training facilities for physicians in the first two plans has barely kept pace with the population growth. The population-physician ratio has remained at 6000:1 over the decade 1951–1961.

Facilities for the training of nurses exist in practically all major hospitals in the country and in the nursing colleges. Although steps have been taken to expand training facilities for nurses and other ancillary personnel, shortages continue to be acute.

The 1960 interim report of the School Health Committee points out that there will be about 50 million children of the age group 6–11 in school by 1966, and that to a large extent the present state of ill health is due to malnutrition and other communicable diseases and conditions which are preventable. The minimum services to be insured in the school health program are:

(1) Clean drinking water and sanitary facilities;
(2) Arrangements for medical inspection;
(3) Follow up services;
(4) Instruction of teachers in health education;

The school midday meal program is being progressively extended as local communities come forward to contribute towards it, especially for children coming from poorer homes.

It was realized as early as the first plan that a great deal of ill health is the result of ignor-

[11] Contributory Health Service Scheme, Central Health Education Bureau, D.G.H.S. Ministry of Health, Government of India, New Delhi, 1958.

TABLE 3. BIRTH RATES, DEATH RATES AND EXPECTATION OF LIFE, 1941–61[12]

Period	Birth Rate	Death Rate	Infant Mortality Rate		Expectations of Life at Birth	
			Male	Female	Male	Female
1941–51	39.9	27.4	190.0	175.0	32.45	31.66
1951–56	41.7	25.9	161.4	146.7	37.76	37.49
1956–61	40.7	21.6	142.3	127.9	41.68	42.06

ance of the simple rules of hygiene and of their practical application. To cater to this important need of health education, the National Health Education Bureau was established in 1956 and several states have since then set up comparable bureaus. Some of the primary objectives of these bureaus may be summarized thus:

1. To provide accurate factual information on current health problems;
2. To motivate people to take action related to personal and community health matters;
3. To fit the new practices wherever possible into the social and cultural context of the villagers;
4. To develop and evaluate educational activities related to particular health problems.

One of the best ways of gauging health progress is by studying the birth and death statistics of the country which, though subject to serious limitations, provide rough estimates in broad terms of the steady improvement in the health of the population. See Table III.

CONTROL OF COMMUNICABLE DISEASE

During the past ten years, substantial progress has been made in controlling various communicable diseases. Programs to control malaria, filariasis, tuberculosis, smallpox, venereal disease, leprosy, and cholera are intended to be stepped up in the third plan period with special emphasis on the eradication of both malaria and smallpox. The total national expenditure for communicable disease control has been tripled since the first five-year plan and is approximately $150 million currently.

Malaria Eradication: The malaria control program launched in 1953 was converted into the national malaria eradication program on April 1, 1958. It is implemented by the National Ministry of Health with the active participation of the state governments as well as with the assistance of the United States Agency for International Development and the World Health Organization. About 382 million people have been given protection by DDT spraying and the percentage of clinical malaria cases treated in hospitals and dispensaries has declined markedly since 1953.

Filaria Control: Filariasis is prevalent mostly in coastal regions. Random sample surveys have revealed that 64 million people live in the filarious areas of the country. Under the National Filaria Control Program mass therapy has been administered to 6.3 million persons and 4.1 million houses have been sprayed with insecticides. Filariasis is predominantly an urban problem and the essential long-term measure is the improvement of environmental sanitation, especially adequate drainage.

Tuberculosis Control: Nearly 5 million persons suffer from active tuberculosis as revealed by the National TB Survey completed in 1958 by the Indian Council of Medical Research. The BCG vaccination campaign, started in 1948 with the help of the International Tuberculosis Campaign and later carried on by WHO and UNICEF, had by the end of the second plan period extended protection to 164 million persons. The third plan will see more demonstration and training centers, 3,500 additional beds and after-care, rehabilitation centers, and mobile clinics for rural areas.

[12] *India 1962*, Publications Division, Ministry of Information and Broadcasting, Government of India, p. 105.

Leprosy Control: The number of leprosy cases in India is now estimated at about 2 million; areas of high incidence have been demarcated and under the leprosy control scheme 135 study and treatment centers had been set up by the end of the second plan. One hundred more control units are planned during the third plan period. A large number of voluntary organizations are also associated with this program.

Venereal Disease Control: It is estimated that five per cent of the population suffer from syphilis and an equal percentage from gonorrhea. Yaws is also present in a few districts of some of the states. A demonstration team established by WHO in Himachal Pradesh in 1949 carried out an extensive survey and a mass treatment program and also trained several teams of Indian health personnel. The introduction of effective methods for the rapid diagnosis and treatment of these diseases has made it possible to reduce the reservoir of infection in the population.

Smallpox: There has been a decline in smallpox morbidity and mortality rates as a result of the vaccination campaigns which have been undertaken; but smallpox cases continue to occur during certain seasons of the year and the disease appears in epidemic form once in five or six years. During the third plan period an effort is being made to eradicate this disease.

Cholera: Cholera is endemic in India especially in the deltaic regions of the principal rivers. Elimination of these endemic foci requires provision of an adequate supply of safe water and sanitary disposal of sewage. In the third plan a substantial program for protected water supply has been drawn up; and it is visualized that the incidence of cholera can be considerably reduced in the third plan and wholly eliminated by the end of the fourth plan.

ENVIRONMENTAL SANITATION

Water Supply: Problems of rural water supply vary from region to region and often within the same region. Rural water supply has been considered mainly under the program for community development. During the first and second plans about 11,000 villages[13] were provided with piped water supply at an estimated cost of $66 million and in the third plan $134 million has been made available. The urban water supply problem is being tackled by the municipalities and corporations with loans provided by the national and state governments.

TABLE 4. POPULATION GROWTH[14]

Census Year	Number in Millions	Increase (+) Decrease (−) over preceding decade (in Millions)
1891	235.9	—
1901	235.5	− .4
1911	249.0	+13.5
1921	248.1	− .9
1931	275.5	+27.4
1941	312.8	+37.3
1951	356.9	+44.1

Disposal of Excreta: Sanitary disposal of excreta is an important national problem. Proper design and construction of village latrines and educational and organizational aspects of the problem have been studied. As the program aims to change the basic habits of the people, it is realized that progress in the beginning will be slow and that health education of the people will form an important component.

Trends in population growth have surpassed all population projections. (See Table 4.) This poses an important problem to a nation struggling for economic stability. The planners recognize "that the objective of stabilizing the growth of population over a rea-

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[13] India has a total of approximately 560,000 villages.

[14] Census of India 1951, Vol. 1, Part 1-A Report, Registrar General, India, and Ex-officio Census Commissioner for India, 1953, pp. 122.

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President Kennedy On Foreign Aid

On April 2, 1963, President Kennedy delivered a message to Congress urging support for his foreign aid program and underlining its importance. Excerpts from his message summarizing his recommendations follow:

* * *

The primary new initiative in this year's program relates to our increased efforts to encourage the investment of private capital in the underdeveloped countries. Already considerable progress has been made fostering United States private investment through the use of investment guaranties—with over $900 million now outstanding—and by means of cost-sharing on investment surveys, loans of local currencies, and other measures provided under existing law. During the first half of this fiscal year alone, $7.7 million in local currencies have been loaned to private business firms.

I believe much more should be done, however, both administratively through more vigorous action by the Agency for International Development, and legislatively by the Congress. Administratively, our Ambassadors and missions abroad, in their negotiations with the less developed countries, are being directed to urge more forcefully the importance of making full use of private resources and improving the climate for private investment, both domestic and foreign. In particular, I am concerned that the investment guaranty program is not fully operative in some countries because of the failure of their governments to execute the normal intergovernmental agreements relating to investment guaranties.

In addition, the Agency for International Development will also strengthen and enlarge its own activities relating to private enterprise—both its efforts to assist in the development of vigorous private economies in the developing countries, and its facilities for mobilizing and assisting the capital and skills of private business in contributing to economic development.

Legislatively, I am recommending . . .:

(A) An amendment to the Internal Revenue Code for a trial period to grant United States taxpayers a tax credit for new investments in developing countries, which should also apply to some extent to reinvestments of their earnings in those countries. Such a credit, by making possible an increased rate of return, should substantially encourage additional private investment in the developing countries. The United States businessmen's committee for the Alliance for Progress has recommended the adoption of such a measure.

(B) Amendments in the investment guaranty provisions of the Foreign Assistance Act designed to enlarge and clarify the guaranty program.

Economic and social growth cannot be accomplished by governments alone. The effective participation of an enlightened United States businessman, especially in partnership with private interests in the developing country, brings not only his investment but his technological and management skills into the process of development. His successful participation in turn helps create that climate of confidence which is so critical in attracting and holding vital external and internal capital. We welcome and encourage initiatives being taken in the private sector of Latin America to accelerate industrial growth and hope that similar cooperative efforts will be established with other developing countries.

* * *

BOOK REVIEWS

History and Politics

THE SOVIET UNION, 1922–1962: A FOREIGN AFFAIRS READER. Edited by Philip E. Mosely. (Published for the Council on Foreign Relations by Frederick A. Praeger, Inc., 1963. 497 pages, and index, $6.95. In paperback, $2.95).

Foreign Affairs, the distinguished quarterly, has recently completed its first 40 years of operation. Its pages have long presented a wealth of stimulating, thoughtful articles. Dr. Philip E. Mosely has selected 30 articles that have stood the test of time and that have relevance for contemporary students of international affairs. He has written a brief commentary on each article which helps place it "in the longer perspective of the development and policies of the Soviet Union." The articles are organized in chronological order: Part I deals with "Revolutionary Russia at the Crossroads, 1922–1929"; Part II with "The Stalinist Revolution, 1929–1945"; Part III with "Stalin's Bid for World Power, 1945–1953"; and Part IV with "Khrushchev's Russia: Old Goals, New Methods, Since 1953." Teachers of Soviet affairs will find this a particularly welcome and valuable anthology.

A.Z.R.

STALIN AND THE FRENCH COMMUNIST PARTY, 1941–1947. By Alfred J. Rieber. (New York and London: Columbia University Press, 1962. 395 pages, bibliography and index, $7.50.)

A history of French Communist activity, between 1941 and 1947, which practically ignores the Communist party's sudden swing from belligerence to pacifism in 1939, the desertion and treachery of leaders like Maurice Thorez, and the Communist approaches to the victorious Germans in occupied Paris a little later, starts out on the wrong foot. We are told, of course, that this is no historical monograph of C.P. policy, but an analysis of how the French and Russian Communist policies interacted, how effective the Russians' influence was, how great the home party's initiative. Even so, a measure of context, an occasional glance beyond the archives and the press, would have put flesh on the book's argument.

In any event, Professor Rieber has given us a kind of diplomatic history, unexciting for the student of Communist affairs, unrewarding to the modern French historian. His conventional view of the French Resistance overrates the role of the Communists and ignores the fact that, after 1935 or 1936, the C.P. became increasingly moderate and opportunistic in comparison with the increasingly revolutionary attitude of the radical right.

Rieber attributes the failure of Communist tactics in France chiefly to Soviet policies. That may be. But he forgets the French—not least Charles de Gaulle; and he forgets the stodgy conservatism of a Communist leadership never more itself than when it turned victory into defeat.

Eugen Weber
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DESIGN FOR TERROR. By Arnold Reifer. (New York: Exposition Press, 1962. 82 pages, and bibliography, $2.50).

The author presents a brief discussion and comparison "of the background, methods, goals and actual operations of the instruments of terror" in Nazi Germany and the Soviet Union. He also shows how terror affects the daily life of the average citizen.

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CANADA

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health care benefits for people receiving categorical allowances. Care for other indigents is through the municipality of residence with partial reimbursement by the province. In Quebec, care for the indigent is provided by religious and other voluntary dispensaries, which may receive government support; elsewhere it is by private arrangement with the doctor and sometimes the municipality. In New Brunswick and Prince Edward Island payment is by private arrangement through the municipality of residence or with a physician. In large cities out-patient care is provided by many public hospitals. Grants may be made by provincial governments and sometimes by municipalities.

In the fiscal year 1961–1962, all levels of government were estimated to have spent approximately $1.094 billion on health or $59.99 per capita. This represents about 2.9 per cent of the Gross National Product.[39] Total personal health care expenditures in 1961 were estimated to represent 4.51 per cent of the Gross National Product.[40]

There is growing awareness that all health services must be regarded as part of a pattern. Concern is expressed about problems such as the distribution of services and facilities, quality of care, regional co-ordination of programmes, more economical use of personnel and facilities, and the evaluation of programmes, as well as the financing of hospital and physicians' care. However, the latter question will doubtless be dominant in the immediate future.

[39] Unpublished data, Research and Statistics Division, Department of National Health and Welfare.

[40] Unpublished data, Research and Statistics Division, Department of National Health and Welfare.

FRANCE

(*Continued from page 358*)

pares the static and even regressive situation in the 1935–1937 period.[24]

A significant reduction in infant mortality, a marked reduction in such diseases as tuberculosis, syphilis, diphtheria, smallpox, and other diseases so rampant during the war and occupation and in the immediate postwar years has taken place. There is great regional variation[25] in health expenditures stemming from disparity in incomes (low rural) and poor distribution of doctors and facilities.

Many doctors are dissatisfied with the social security provisions for medical care and the profession itself has been divided. There is, on the other hand, evidence of considerable sober reappraisal of the role of medicine in a "welfare state" context. It ought to be noted that the French medical profession remains one of the freest in western Europe. Materially, the French doctor has gained, a sure clientèle exists, medical consumption continues to rise, and the payment of fees is guaranteed.

The growth of consumer demand for medical care is a worldwide phenomenon. Many factors contribute to this rise. Among those often cited are the rapid advance of medical science, the rising standards of living, the improved communications and transportation network, and a changing demographic and morbidity pattern as well as the growth of social institutions for translating this demand into relevant social and health services. The French system has not been able to resist this tide and is making its contribution to social welfare while maintaining a considerable emphasis on the individual.

[24] *See C.A.F.*, February, 1963, p. 251. Bulletin Mensuel, Union Nationale des Caisses d'Allocations Familiales, Paris.

[25] See Henry Rosen, "La Sante," *Succès et Faiblesse de l'Effort Social Français*, Paris, Armand Colin, 1961, pp. 95–101.

THE OUTLOOK FOR MEDICINE

(*Continued from page 325*)

and aid to medicine feel that those in the lower income groups should not be discriminated against, that the health of the people, like education, is a public charge. Although not often overtly stated, proponents think that the individual has a right to necessary medical care, and that he should get it not

as charity but as his due from the government. This is perhaps one of the most important considerations.

A large proportion of both the public and the medical profession who express definite ideas concerning socialized medicine have no knowledge of either the Kerr-Mills or the Anderson-King proposals. Their opinions are largely emotional, based on a number of factors: opposition to the A.M.A., a preference for all kinds of security that can be provided by the government, the idea that they will get something for nothing, or that the rich will have to pay. On the other hand, others feel that they will not be able to choose the doctor, or they fear that anything "socialized" opens the door to "communism."

Besides those politicians who want to extend their control and influence, there are bureaucrats who honestly think that the government has an opportunity to extend its usefulness to the citizens. Parenthetically it is a human tendency to expand, to extend one's empire, a tendency which exists in nearly all institutions, non-government as well as government.

The national health services in the several countries vary in their comprehensiveness, according to national characteristics, politics and cultures. In the countries considered in this article, the death rates are approximately the same as they are in the United States and necessary public health measures (sanitation, prophylaxis) are carried out by the respective governments. Nationalization of medicine, therefore, has to do largely with surgical treatment, chronic and incurable illness or diverse minor ailments. The trend in medicine, as in other services, is toward some kind of security, paid for through universal taxes and administered by a central authority. In the United States, the decision will probably be made on emotional and political rather than economic grounds. The sheet of economic reckoning will be swept out by winds of politics and sentiment.

BIBLIOGRAPHY

1. Allday, R. K., *Medicine in Britain and the National Health Service,* Bristol, 1962.
2. Bugbee, George, *et al,* "High Cost of Health," *Social Action,* V. XXVII, No. 7, March, 1961.
3. Cookson, J. S., "Public Health Services in Scandinavia," *Public Health,* 76: 353–9, Sept., 1962.
4. Eckstein, Harry, *The English Health Service,* Cambridge, Mass., 1958.
5. Gantt, W. H., *Medical Review of Soviet Russia,* British Medical Association, London, 1928, p. 112.
6. Gantt, W. H., *Russian Medicine,* Hoeber & Co., N. Y., 1937, p. 214.
7. *Health Services in the U.S.S.R.,* WHO, Geneva, 1960.
8. Judd, W. H., "Quality of Medicine," *AMA News,* May 15, 1961, V. 4, No. 11.
9. Lindsey, A., *Socialized Medicine in England and Wales,* Chapel Hill, N. C., 1962.
10. Mackarness, R., personal communication.
11. Nelson, George R., *Social Patterns in the Northern Countries of Europe,* Copenhagen, 1953.
12. Norton, Howard, *Baltimore Sun,* March, 1959.
13. Robinson, Kenneth, "The Case for Britain's Health Service," *N. Y. Times Magazine,* Nov. 18, 1962, pp. 42–50.
14. Semashko, N. A., *Health Protection in the U.S.S.R.,* London, 1934.
15. Statement of the American Medical Association, *J.A.M.A.,* V. 177, pp. 368–370, Aug. 12, 1961.
16. Tait, W. G., *Medical World News,* March, 1963.

BOOK REVIEWS

(*Continued from page 367*)

SOVIET RUSSIA IN WORLD POLITICS. By Robert D. Warth. (New York: Twayne Publishers, Inc., 1963. 544 pages, bibliography and index, $7.50.)

In his introduction, Robert Warth notes that his book "claims no 'inside information' and presents no certain answers to the 'riddle of the Kremlin.' But it does attempt to provide an accurate, objective, and reasonably complete historical account of Soviet foreign relations." In this he has succeeded eminently. This readable, informative narrative will serve as a fine introduction to the complex, and often perplexing, subject of Soviet foreign policy. A.Z.R.

THE MONTH IN REVIEW

A CURRENT HISTORY Chronology covering the most important events of April, 1963, to provide a day-by-day summary of world affairs.

INTERNATIONAL

Berlin

April 4—U.S. chief delegate to the U.N. Adlai Stevenson tells the West Berlin parliament that the U.S. will defend Western rights in the city.

April 12—U.S. Secretary of State Dean Rusk confers with Soviet Ambassador Anatoly F. Dobrynin in Washington on the Berlin question.

Central Treaty Organization

April 27—The 13th meeting of the Central Treaty Organization Military Committee opens in Teheran; General Maxwell Taylor, chairman of the U.S. Joint Chiefs of Staff, heads the U.S. delegation.

April 28—U.S. Secretary of State Dean Rusk leaves Ankara for Teheran for further conferences en route to the Cento meetings in Karachi.

April 30—Foreign ministers of Cento begin their conference in Karachi; Pakistani President Mohammad Ayub Khan is not present to welcome the delegates as usual, but sends a message.

Disarmament

April 24—President Kennedy tells his news conference he is afraid that "time is running out," as Soviet Premier Nikita Khrushchev rejects the latest Western attempts to revitalize nuclear test ban treaty negotiations.

April 29—The U.S.S.R. says the 17-nation disarmament conference is a "waste of time."

European Economic Community (Common Market)

April 8—An unpublished memorandum of the Council of Ministers outlines an agreement in principle among the 6 Common Market nations to cooperate with the Inter-American Development Bank to finance Alliance for Progress projects in Latin America.

North Atlantic Treaty Organization

April 7—In conversations with U.S. Secretary of State Dean Rusk in Paris, French Foreign Minister Couve de Murville asks about plans for the projected interallied nuclear force. (See also *France.*)

April 23—Dirk U. Stikker, Secretary General of the North Atlantic Treaty Organization, expresses the hope that France will participate in the Nato nuclear force.

Organization of American States

April 23—The Organization of American States authorizes the O.A.S. Council to investigate Communist subversion by the Castro regime anywhere in the Western Hemisphere even without permission of a member government.

April 29—A joint declaration of 5 Latin American states recommends a regional agreement forbidding nuclear arms in Latin America. The 5 sponsoring states are Bolivia, Chile, Ecuador, Mexico and Brazil.

April 30—An O.A.S. commission arrives in Haiti to investigate the Haitian dispute with the Dominican Republic. (See also *Haiti.*)

Southeast Asia

April 3—The second session of the 3-day ministerial conference of the Association of Southeast Asia begins to plan a limited free-trade area for Malaya, Thailand and the Philippines.

April 10—The 8 Seato nations reiterate their support for a neutral, independent Laos, at the close of a 3-day meeting.

United Nations

April 4—The United Nations committee on ending colonialism votes to ask Security Council action against Portugal on her treatment of African colonies; the U.S. objection is over-ridden.

April 8—The U.S.S.R. states that it will not accept "any financial consequences" of U.N. police forces in the Middle East and the Congo.

April 24—The Security Council votes unanimously to "deplore" the Portuguese bombing of a village in Senegal April 8. Portugal has denied that the incident took place.

April 29—Kuwait applies for admission as the 111th member of the U.N.

ALGERIA

April 12—It is reported that yesterday at noon Foreign Minister Mohammed Khemisti was shot by a Muslim in Algiers. He is critically wounded.

April 17—The government-owned radio station announces that Mohammed Khider has resigned as Secretary General of the National Liberation Front's political bureau. Ben Bella takes over the post.

ARGENTINA

April 2—A rebel naval force led by a group of retired army and air force officers fights with government tanks near La Plata.

April 5—The government announces that an agreement has been reached with rebel leaders, ending the 4-day revolt by the navy. The rebels are reported to have acted to protest national elections scheduled for June, 1963, in which a party loyal to ex-dictator Juan D. Perón will campaign.

April 9—General Enrique Rauch is sworn in as interior minister, succeeding Rodolfo Martinez, who resigned on February 27. A communiqué after a Cabinet meeting reaffirms that elections will be held on June 23.

April 19—It is reported that on April 17 Interior Minister Rauch ordered the arrests of 50 persons.

AUSTRIA

April 28—Elections for the presidency are held. Adolf Schärf is re-elected over his 2 opponents; Schärf has already served one 6-year term.

BRAZIL

April 20—Brazil and the Soviet Union sign a three-year trade agreement.

BRITISH COMMONWEALTH OF NATIONS

Canada

April 8—General elections are held in Canada; unofficial returns give Lester Pearson's Liberal party a lead over Prime Minister John Diefenbaker's Conservative party.

April 13—Diefenbaker concedes his defeat. The Liberals hold 130 seats, just short of a majority, in the 265 seat House of Commons. The vote of the armed forces strengthens the Liberals.

April 22—Pearson becomes 14th Prime Minister of Canada.

April 24—Pearson announces that he will fly to London May 1 for 2 days of conferences with British Prime Minister Harold Macmillan.

Great Britain

April 3—Chancellor of the Exchequer Reginald Maudling announces tax reductions totalling £269 million ($753.2 million); the new budget carries the theme

"expansion without inflation." Total revenue is estimated at £7.424 billion; total expenditures at £8.121 billion.

April 4—Japan and Britain exchange instruments of ratification of their treaty of commerce and navigation, to go into force May 4.

April 9—Sir Winston Churchill becomes an honorary citizen of the U.S.

April 10—Commons votes 274 to 218 to endorse the decision of the Home Secretary, Henry Brooks, to deport Nigerian Chief Anthony Enahoro to Nigeria; he faces trial on a charge of treasonable felony and possible imprisonment.

April 15—Some 70,000 persons protest British nuclear arms at a Hyde Park rally.

April 23—Raiders from Indonesian Borneo attack British troops in Sarawak.

April 25—The Admiralty and security services are cleared of responsibility for conditions that permitted Admiralty clerk William Vassall to spy for the U.S.S.R. in the Admiralty for more than 7 years.

It is announced in London that 8 Caribbean governments have been invited to London in June to confer on a new federation for the east Caribbean colonies.

India

(See also *Pakistan.*)

April 8—Parliament approves a defense budget providing for an expenditure of some $1.82 billion; the Defense Ministry plans to double the army in 2 years' time.

April 11—Troops are sent to stop violence in Nagaland.

Chinese forces release 144 Indian prisoners on the India-Tibet frontier. (See also *China.*)

April 16—Prime Minister Jawaharlal Nehru expresses opposition to the suggestion that the Vale of Kashmir might be partitioned; the suggestion reportedly has been made by Western powers.

April 23—"Little progress" is reported at the fifth Indian-Pakistani conference on Kashmir.

April 25—The sixth round of conferences on Kashmir is scheduled for May 15 in New Delhi. Pakistani representatives indicate this will be the last round.

April 27—Parliament votes to continue the use of English as an official language second to Hindi in India until 1975.

Pakistan

(See also *India.*)

April 8—The Government scores India's "mischievous suggestion" that Pakistan surrendered 2,000 square miles of territory to China in its recent border agreement.

April 10—Foreign Minister Zulfikar Ali Bhutto says that neither the U.S. nor any other government has suggested that Kashmir be partitioned.

BRITISH EMPIRE

Federation of Rhodesia and Nyasaland

April 8—The Earl of Dalhousie, Governor General of the Federation, opens the new session of Parliament and charges that Britain has "betrayed" the people of the Federation. On March 31, the British Government announced that Northern Rhodesia, Southern Rhodesia and Nyasaland had equal rights of secession from the federation.

April 11—In London, R. A. Butler, Minister for Central African Affairs, reveals that the Government is rejecting the request of the all-white government of Southern Rhodesia for early independence.

April 19—Federation Prime Minister Sir Roy Welensky announces the dissolution of his United Federal party. The new Federal party takes over to insure "an orderly redistribution of power" as the federation dissolves.

Former Southern Rhodesian Prime Minister Sir Edgar Whitehead announces the establishment of the Rhodesian National party, which opposes a Southern Rhodesian seizure of independence in the face of British delay.

CHINA, PEOPLE'S REPUBLIC OF (Communist)

April 2—Communist China announces that some 3,213 Indian troops captured in border fighting will be repatriated beginning April 10.

April 12—Chairman of the People's Republic of China Liu Shao-chi arrives in Indonesia for a 9-day visit.

CONGO, REPUBLIC OF THE (Leopoldville)

April 9—In a letter to U.N. Secretary General U Thant (made public today), Premier Cyrille Adoula states that U.N. forces should remain in the Congo "for some time yet."

April 17—Adoula announces that a new "Government of National Reconciliation" has been formed. The new Cabinet contains a large number of Opposition members.

CUBA

(See also *U.S.S.R.* and *U.S. Foreign Policy.*)

April 1—A 35-foot motor launch carrying a cannon and 2 machine guns with 17 Cubans aboard is seized by a British force in the Bahamas.

April 3—At a news conference U.S. President Kennedy states that some 4,000 Soviet troops left Cuba in March.

April 9—Chairman of the U.S.-based Cuban Revolutionary Council Jose Miro Cardona resigns. Miro had threatened to resign unless the U.S. promised to help him stage an invasion of Cuba. (See also *U.S. Foreign Policy.*)

April 10—The Cuban Revolutionary Council rejects Miro's resignation.

April 15—The U.S. State Department issues a statement declaring that Miro's charges against Kennedy are "highly inaccurate and distorted."

FRANCE

April 3—French mine union officials and leaders of the nationalized coal industry agree on a wage increase of 8 per cent beginning with a 6.5 per cent increase from now until October 1. (By April, 1964, the increase will mount to 12.5 per cent).

April 4—Union leaders order coal miners back to their jobs tomorrow.

April 8—U.S. Secretary of State Dean Rusk meets in Paris with French President Charles de Gaulle to discuss the question of nuclear weapons in Nato. De Gaulle is reported willing to discuss a Nato nuclear force as agreed on in December, 1962, by the U.S. and Britain.

April 19—In a television broadcast, de Gaulle urges France to be "her own master"; he concedes the necessity of an Atlantic alliance and mutual defense. He urges that France develop an independent nuclear striking force. (See also *International, Nato.*)

GERMANY, FEDERAL REPUBLIC OF (West)

April 14—Some 14 members of West Germany's coalition government meet with Chancellor Konrad Adenauer at his vacation retreat in Italy. The 14 leaders agree to insert a declaration in the preamble of the law ratifying the Franco-German treaty of January, 1963. The insert will reaffirm West Germany's loyalty to the Atlantic alliance and European unity.

April 15—It is reported that parliamentary leader of the Christian Democratic Union Heinrich von Brentano. in talks yesterday and today, informed Adenauer that the C.D.U. supports Economics Minister Ludwig Erhard to succeed Adenauer.

April 22—The 56-member governing body of the C.D.U. and the Christian Social Union (Bavarian affiliate of the C.D.U.) agrees unanimously to recommend to its parliamentary members that Erhard succeed to the chancellorship. The party will be requested to announce the nomination to President Heinrich Luebke; in effect Erhard's succession becomes official. Adenauer will step down in October.

April 23—Parliamentary members of the C.D.U. and the C.S.U. vote approval of the nomination of Erhard to succeed Adenauer.

GUATEMALA

April 10—The new military government issues an interim "Basic Government Law" giving public power to the army.

April 17—The U.S. recognizes the new Guatemalan government.

HAITI

April 26—Gunmen shoot and kill 4 palace guards escorting President Francois Duvalier's 2 children from the Palace to school. The children are unharmed.

April 28—At an emergency session of the Council of the Organization of American States, the Dominican Republic charges Haiti with aggressive policies, in particular the occupation of the Dominican embassy in Haiti by Haitian troops on April 26. Haiti denies the charges. The Council appoints an investigating team to go to Haiti.

April 29—It is announced that Haiti has agreed to restore diplomatic privileges to the Dominican embassy.

The U.S. State Department announces that a group of 30 marines will be withdrawn at Haiti's request; the marines had helped train Haitian troops. The request pre-dates the Haitian-Dominican conflict.

INDONESIA

April 20—President Sukarno and visiting Chinese Communist leader Liu Shao-chi issue a joint statement at the end of Liu's 8-day visit: Sukarno supports Communist China's policies in Asia and Red China endorses Indonesia's opposition to a Malaysian federation.

IRAN

April 23—Premier Assadollah Alam announces that general elections will be held in June, 1963. For 2 years the Premier has ruled without Parliament.

IRAQ

(See *U.A.R.*)

ISRAEL

April 23—Israeli President Itzhak Ben-Zvi dies at the age of 78.

ITALY

April 28—Elections for the Chamber of Deputies and the Senate are held.

April 30—Election returns reveal that Premier Amintore Fanfani's Christian Democratic party lost 13 seats in the Chamber of Deputies and received 757,000 fewer votes than in the 1958 election. The Communist party gained 1,059,000 votes over the last election, and increased its strength by 25 new seats in the Chamber.

JORDAN

April 20—In Amman, street demonstrations support Jordan's joining the federation of the U.A.R., Iraq, and Syria. Jordanian Premier Samir el-Rifai resigns, after 32 of the 60 parliamentary members have spoken in opposition to Rifai's handling of the Arab unity question.

April 21—King Hussein names his uncle, Sherif Hussein Ibn Nasser, to be caretaker premier until elections are held, within the next 4 months. Parliament is dissolved.

April 23—It is reported that 11 members of the ousted Rifai cabinet have been arrested; they are charged with involvement in pro-Nasser rioting.

KOREA, SOUTH

April 1—Civilian leaders agree to meet with the ruling military junta to discuss a coalition government. The civilian leaders have insisted that the junta honor its promise to hold elections. The junta has declared that it needs 4 more years of power.

April 3—It is reported that the U.S. has privately told South Korean officials that the U.S. will reduce its economic aid. The U.S. aid cut-off was decided before the current civil-military conflict.

April 6—It is reported that General Park has agreed to hold elections this fall; he also accepts the plan for an interim coalition

government of military and civilian leaders to prepare the country for the elections.

LAOS

April 2—Official government sources announce that Foreign Minister Quinim Pholsena was assassinated last night.

It is reported that a neutralist guard has confessed to assassinating the pro-leftist foreign minister.

April 6—It is reported that pro-Communists are battling General Kong Le's troops in the Plaine des Jarres in the northeast. Kong Le supports Premier Souvanna Phouma and his neutralist policy. The fighting is another round in the series that began on March 31, 1963.

April 8—The U.S. State Department charges that the pro-Communist forces are guilty of violating the cease-fire in Laos. The U.S. declares that there are indications that pro-Communist Pathet Lao troops are receiving North Vietnamese support. The U.S. also asks that Britain and the U.S.S.R. (co-chairmen of the 14-nation Geneva conference on Laos) take immediate steps to end the conflict in Laos. (See also *U.S. Foreign Policy.*)

It is reliably disclosed that Laos has asked the International Control Commission on Laos (Canada, India and Poland) to send inspection teams to the Plaine des Jarres.

April 14—Premier Phouma, after a one-day trip to the Plaine des Jarres, declares that he has arranged an interim ceasefire. Phouma states that Kong Le and General Singkapo Chounramany (pro-Communist) have agreed to stop fighting until he can "arrange a definite settlement."

April 15—It is reported that new fighting has broken out on the Plaine des Jarres.

April 19—Phouma asks the Soviet Union and Britain to intervene to end the Pathet Lao attacks on loyal Laotian troops.

April 20—The Pathet Lao force General Kong Le's forces to retreat from their headquarters at the Plaine des Jarres airport.

U.S. Secretary of State Dean Rusk meets separately with the members of the I.C.C. for Laos.

April 21—Phouma declares that he has received a pledge from pro-Communist leaders that they will adhere to a new ceasefire agreement. Phouma returns from a hurried trip to the Plaine des Jarres.

April 23—It is reported that in an exchange of correspondence between Soviet Foreign Minister Andrei Gromyko and British Foreign Minister Lord Home, Britain and the Soviet Union have not been able to agree on a Laotian settlement.

April 26—Soviet Premier Khrushchev and U.S. envoy W. Averell Harriman confer in Moscow. They issue a joint statement voicing support for the Geneva agreement, whereby it was decided to establish a unified Laos under a neutralist government. The statement does not include any commitment by the Soviet Union to interfere actively in promoting peace in Laos.

MOROCCO

April 6—King Hassan II returns to Morocco after a 10-day visit to the U.S.

April 17—King Hassan announces that elections for the first House of Representatives for Morocco will be held in May.

NEPAL

April 13—The state of emergency proclaimed in 1960 is lifted.

April 19—The new parliament is inaugurated by King Mahendra. It is the first parliamentary session since 1960.

SENEGAL

April 9—A communiqué is issued by Senegal charging that 4 Portuguese military planes have bombed a Senegalese village along the Portuguese Guinea border.

April 17—The Security Council hears Senegalese charges against Portugal. (See also *International, U.N.*)

SOUTH AFRICA, REPUBLIC OF

April 23—The Minister of Justice, Balthazar J. Vorster, tells a press conference of a

new bill which will give the government greater power to repress saboteurs and those advocating the overthrow of the government. The general law amendment bill also provides that persons can be held for successive 90-day periods without trial.

April 29—The general law amendment bill is approved by the lower house of parliament. The bill must be passed by the Senate.

The Bar Council in Johannesburg condemns the bill as "the virtual end of the rule of law in South Africa."

SPAIN

April 18—Julian Grimau Garcia, who aided the Communists during the Spanish civil war of 1936–1939, is sentenced to death by a Spanish military tribunal. He was arrested in Spain in November, 1962.

SYRIA

(See also *U.A.R.*)

April 1—A state of emergency is proclaimed by the Revolutionary Command Council and an 18-hour curfew is declared in Damascus following pro-Nasser rioting.

U.S.S.R., THE

April 2—The Soviet Union announces that it has successfully launched a fourth moon shot, Lunik IV. The rocket weighs 3.5 tons.

In a letter from the Soviet Union to Communist Chinese Premier Chou En-lai and signed by the Central Committee of the Soviet Communist party, Premier Khrushchev refuses Red China's invitation to visit Peking to iron out ideological problems. Instead, the Soviet Union suggests that Chairman of the Chinese Communist party Mao Tse-tung visit Moscow.

April 6—A communiqué announces that Lunik IV passed the moon at a distance of 5,300 miles, and will eventually go into orbit around the sun.

April 9—In notes yesterday to Britain, West Germany, the U.S., France, and the other Nato members made public by *Tass*, the Soviet Union warns that if a nuclear force is established within Nato, world security will be threatened and disarmament negotiations will be stalemated for 10 years.

April 16—The young Soviet pianist, Vladimir Ashkenazy, on a conceert tour, decides to remain in Britain with his wife and child.

April 20—*Izvestia* (government newspaper) announces that the Council of National Economy has recently ordered an increase in the 1963 consumer goods plan of approximately 2 per cent, or about $1 billion.

April 25—*Tass* (official Soviet press agency) presents a summary of and excerpts from a speech by Premier Nikita Khrushchev before an industrial conference attended by party and economic leaders in the Russian Republic. Khrushchev stated yesterday that at his age, 69, he cannot hold all his positions forever.

April 27—Cuban Premier Fidel Castro arrives in the Soviet Union on a visit at the invitation of Premier Khrushchev.

April 28—Castro expresses gratitude for Soviet aid in preventing "imperialist aggression against" Cuba.

UNITED ARAB REPUBLIC

(See also *Yemen.*)

April 7—Talks open in Cairo on an Arab federation. President Gamal Abdel Nasser represents Egypt; Premier Salah el-Bitar, Syria; and Premier Ahmed Hassan Bakr, Iraq.

April 8—U.A.R. Prime Minister Aly Sabry announces that Iraq, Syria and the U.A.R. have reached agreement on all the principles for union; the job of drawing up a national charter for the union is given to a 3-power subcommittee.

April 10—Sabry announces the outlines of the new federation: Iraq, Syria and Egypt will merge as the United Arab Republic; the 3 states will share one nationality and one diplomatic representative; there will be a president and a federal council.

April 17—Egyptian, Syrian and Iraqi representatives sign a communiqué revealing

that the projected federation will be submitted to national plebiscites on September 27, 1963.

The Syrian and Iraqi premiers return home.

UNITED STATES

The Economy

April 4—The Labor Department reports employment in March rose by 800,000 to a record for March of 67,148,000.

April 10—The Wheeling Steel Corporation announces steel price increases.

April 11—President Kennedy says he will not oppose rises in prices of selected steel products.

April 14—The Lukens Steel Company announces increases in the price of plate steel.

April 15—Republic Steel raises some prices.

April 16—The U.S. Steel Corporation raises some prices.

April 17—Kaiser Steel raises prices.

April 19—The President says the steel industry "has acted with some restraint."

The President's Council of Economic Advisors reports that the gross national product has risen to a record annual rate of $572 billion in the first quarter of 1963.

Foreign Policy

(See also *International, Nato.*)

April 2—President Kennedy asks Congress for an authorization of $4,525,000,000 in foreign aid funds, a reduction of $420 million from his January budget estimate. He asks also for tax incentives to stimulate private investment capital flow into developing nations.

The U.S. reveals that on March 30 a Cuban rebel trading boat was seized in Miami.

April 4—At a conference in Managua, representatives of Central American nations agree to ask their governments to approve resolutions tightening defenses against Cuban subversion in Central America. (See also *International, Latin America.*)

April 5—The U.S.S.R. accepts the proposal to establish a direct communication line between Moscow and Washington to reduce the possibility of accidental war.

April 6—The U.S. and Britain sign a technical agreement providing for U.S. sale of Polaris missile models without warheads to Britain for use with still-unbuilt British nuclear submarines.

Chester Bowles is named U.S. Ambassador to India.

April 10—General Lucius Clay, head of a presidential advisory commission on foreign aid, suggests a larger reduction in foreign aid spending.

April 18—Resigning as president of the Cuban Revolutionary Council, José Miro Cardona publishes a 23-page report attacking the Kennedy administration's Cuban policies. (See also *Cuba.*)

April 19—The President denies that any official of his administration ever pledged a second invasion of Cuba.

April 22—It is reported in Washington that the Navy is engaged in "precautionary" activities in the Gulf of Siam because of the Laotian crisis. (See also *Laos.*)

April 24—President Kennedy reveals that he is sending W. Averell Harriman as his personal representative to Moscow to discuss the Laotian crisis with the Soviet Union.

April 30—Officials in Washington reveal that United States Ambassador to the U.S.S.R. Foy D. Kohler will not attend Russia's May Day celebrations because Cuban Premier Fidel Castro will be present.

Officials in Miami reveal that the U.S. has withdrawn support from the Cuban Revolutionary Council.

Government

April 2—In a unique action, Congress sends the President a measure approving Sir Winston Churchill as an honorary citizen of the U.S. (See also *British Commonwealth, Great Britain.*)

April 3—The Securities and Exchange Commission reports "grave abuses" in the securities market and asks Congress for "additional controls and improvements."

More than 30 specific changes are proposed.

April 5—The White House announces that J. Robert Oppenheimer has been chosen to receive the $50,000 Fermi Award for 1963 by the Atomic Energy Commission. In 1954, Oppenheimer was declared a security risk by the A.E.C. after 10 years of service as a leader in nuclear research for the U.S.

April 11—The White House sends Congress a bill providing for a thousand-member domestic peace corps, the National Service Corps.

April 23—The President names Clark M. Clifford to replace James Killian as chairman of the Foreign Intelligence Advisory Board.

Labor

April 3—President Kennedy names an emergency board to investigate the railroad work rules dispute; a threatened strike is postponed at least 60 days.

John L. Lewis of the United Mine Workers is honored at a luncheon given by the national coal policy conference as he retires as chairman.

April 7—The 4-month newspaper strike in Cleveland ends.

April 27—The presidential emergency board gives confidential memos to unions and carriers as it investigates the deadlock over railroad work rules.

Military

April 5—The Senate Investigating Subcommittee asks the General Accounting Office to investigate the "cost standards" used in making the TFX airplane contract award to the General Dynamics Corporation.

April 7—It is revealed in Washington that the Navy has suggested to the Defense Secretary that all major naval vessels henceforth be built with nuclear-powered engines.

April 8—Secretary of the Navy Fred Korth announces that Vice Admiral Hyman Rickover will remain in the Navy's nuclear propulsion program after compulsory retirement from active duty in 1964.

April 10—The Navy reveals that the atomic submarine Thresher and its 129-man crew appears to be lost after a deep test dive in water 8,400 feet deep 220 miles east of Boston.

April 11—The Navy gives up hope for the 129 crew members on the Thresher.

April 23—The Polaris-firing nuclear submarine Lafayette joins the U.S. fleet.

April 24—The nuclear-powered attack submarine Jack, the same class as the Thresher, is launched at the Portsmouth Naval Shipyard.

April 27—The Daniel Webster, 20th Polaris-firing submarine in the U.S. Navy, is launched at Groton.

Politics

April 1—Karl F. Rolvaag becomes the governor of Minnesota after a recount gives him a 91-vote victory in the November, 1962, elections.

April 2—Unofficial returns in the Michigan referendum show voter approval for Michigan's new constitution; this vote is a personal triumph for Republican Governor George Romney.

April 20—Former Vice-President Richard Nixon calls for a new foreign policy with a new "freedom doctrine" for the Americas.

Segregation and Civil Rights

April 3—Nineteen Negro protest marchers are arrested in Greenwood, Mississippi.

April 9—A federal appeals court divides on the question of granting a jury trial to Mississippi Governor Ross Barnett; the question goes to the Supreme Court.

April 12—Martin Luther King is arrested for defying a court injunction and leading Negro protest marchers toward downtown Birmingham, Alabama.

April 16—President Kennedy is asked by the Civil Rights Commission to deny federal funds to Mississippi until the state ends its "subversion of the Constitution."

April 18—Florida ratifies an amendment to

the federal constitution outlawing poll taxes, the 31st state to take this action. Seven more states must ratify to make the amendment effective. Only 5 states now collect a poll tax.

April 19—President Kennedy states that he is not empowered to deny funds to Mississippi nor does he want such power.

April 20—Martin Luther King is released from Birmingham City Jail after posting bond.

The U.S. Office of Education reports that in the fall of 1963 250,000 children in Southern communities will attend integrated schools, when communities where federal bases are located desegregate their schools by request of the federal government.

April 27—Eight more Negroes are arrested in the 25th day of protests against segregation in Birmingham, Alabama.

Supreme Court

April 15—The Court unanimously orders dismissal of a suit brought by landowners against the Great Central Valley reclamation project in California; the Court rules that government seizure of the affected landowners' water rights is legal and that formal lawsuits were not required prior to the seizure.

April 22—The Court unanimously reverses an order of a 3-judge federal district court; the lower court held that a Kansas statute prohibiting "debt adjustment" was unconstitutional; the Supreme Court upholds the Kansas statute. Justice Hugo Black declares that the Court refuses "to sit as a super-legislature to weigh the wisdom of legislation."

The Court rules unanimously that states are empowered to force interstate airlines to stop racially discriminating hiring practices.

April 29—The Court rules unanimously that it is unconstitutional to segregate by race in any courtroom in the United States. The case under discussion involves a traffic court in Richmond, Virginia.

VATICAN, THE

April 9—Pope John XXIII signs an encyclical in which the views of the Roman Catholic Church on peace in the twentieth century are elaborated.

April 10—The encyclical, *"Pacem in Terris"* (Peace on Earth), is published. The encyclical advocates a supernational community.

VIETNAM, SOUTH

April 17—President Ngo Dinh Diem, in a nationwide broadcast, urges Viet Cong guerrillas to end the civil war. He promises them financial aid and government jobs.

April 28—In the north, a battalion of South Vietnamese troops clashes with 2 battalions of Viet Cong rebels, according to U.S. military sources. Some 40 Vietnamese troops and an American sergeant are killed.

YEMEN

April 10—U.S. special envoy Ellsworth Bunker confers in Cairo with President Nasser in efforts to have the U.A.R. and Saudi Arabia halt their aid to the opposing factions in Yemen.

April 13—It is reported that the U.A.R. and Saudi Arabia have tentatively agreed to stop assisting the royalists and the republicans in the Yemen civil war.

It is reported that the Sana radio has broadcast the text of Yemen's first interim republican constitution.

It is reported that a presidency council has been set up to act in place of the National Revolutionary Council.

YUGOSLAVIA

April 7—The federal parliament unanimously approves a new constitution under which President Tito will remain in office for life. Future presidents will be elected by parliament for a maximum of 2 consecutive 4-year terms. The new constitution also provides for a Communist-controlled state, and creates the post of premier. The new name of the country is "The Socialist Federal Republic of Yugoslavia."

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INDIA

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sonable period must be at the very center of planned development," and again that "in the circumstances of the country, family planning has to be undertaken not merely as a major development of program but as a nationwide movement which embodies a basic attitude towards a better life for the individual, the family, and the country." The allocation of funds shows the top priority nature of the program; the funds have increased from $1.47 million in the first plan to $6.30 million in the second and to $56.7 million in the third, with a possibility of extending it to $105 million.

Other areas holding government attention and in no way less important are nutrition, maternal and child health, mental health, improvement in collection of vital statistics, drug control and food adulteration, and promotion of research in indigenous systems of medicine (ayurveda, unani, homeopathy, and nature cure).

Although statistics show considerable progress in health, there are marked gaps which become obvious when the resources and facilities for health care are analyzed. In relation to needs the institutional facilities are quite inadequate, more so in rural areas, where the need is greater. Doctors also are unevenly distributed and again the shortages are mainly in the rural areas. Shortages of trained personnel, supplies and equipment have in instances been major barriers in control of communicable diseases. The persistence of intestinal diseases as a major public health problem is explained by the lack of safe water supply and proper sewage disposal. These problems are further exaggerated because of the rapid population growth. Although there has been a 22 per cent rise in national income since 1949 the per capita income has remained about the same (an annual increase of only $10 from 1949 to 1959).

In 1959 the government appointed the Mudaliar Committee to evaluate the health programs in the country and to make recommendations. The Committee submitted its report in 1961 and this is currently being reviewed.

The aim of the government to provide a good life for the 400 million people of India remains unshaken, and the achievement of this goal, though far off, is seen as a reality. The planning experience of the last ten years and the large social and economic changes that have already taken place have brought a conviction that India can look forward to sustained progress.

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